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ABSTRACT

This interdisciplinary inservice training project at the University of Illinois at Chicago was designed to improve early childhood occupational and physical therapy services by developing, implementing, evaluating, and disseminating a comprehensive training model. The competency-based program was designed to address the developmental needs of practitioners, from foundational skills to advanced practice competencies. The program allowed therapists who were working to remain in the provider pool while enhancing their skills. Participants collaborated with project faculty and clinical supervisors in developing individualized learning contracts. Foundational Level therapists enrolled in a lecture series and completed an extensive supervised practicum. Training at the Enrichment Level included completion of a continuing education program involving didactic sessions and videotape case analyses. Advanced Level training addressed highly specialized competencies that required practicum experiences supervised by qualified practitioners. Follow-up activities for participating therapists included seminar meetings emphasizing faculty and peer review. Appendices contain competency statements; a parent advisory committee report; the Individual Learning Plan; various evaluation forms; a reprint of an article by Mary C. Lawlor and Elizabeth A. Cada titled "Partnerships between Therapists, Parents, and Children"; and results of a survey of 276 occupational and physical therapists in Illinois. A participant's guide titled "Forming Partnerships with Families" is also provided. It includes information and exercises for a self-paced, video-based course dealing with the family, interpersonal relationships, the multidiscilinary conference meeting, and development of the Individualized Family Service Plan. The participant's guide is accompanied by three videotape recordings. (Contains 19 references.) (JDD)

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The UIC Therapeutic Partnership Project

Final Report

Early Education Program for Children with Disabilities
U.S. Department of Education
Grant Number: H024P00028

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II. Executive Summary

Occupational and physical therapists provide essential services to infants and young children and their families and bring unique perspectives to multidisciplinary and interdisciplinary early childhood teams. Their contributions are particularly evident in situations where early childhood development is disrupted by disabilities or vulnerabilities in gross motor, fine motor, sensory, play, and activity of daily living domains. Services are typically provided in a variety of settings and involve combinations of consultative, indirect, and direct services.

There is a severe shortage of qualified occupational and physical therapy personnel to meet the needs of young children with disabilities and their families. Even greater shortfalls are projected as states fully implement P.L. 99-457. Unless additional therapists are recruited into early childhood programs, and the skills of current practitioners enhanced and upgraded, young children and their families will not have access to necessary and beneficial therapeutic services.

This interdisciplinary inservice training project was designed to improve early childhood therapy services and substantially increase the provider pool by developing, implementing, evaluating, and disseminating a comprehensive inservice training model. We targeted two groups of therapists: 1) therapists who were not working currently, or who were working outside early childhood; and 2) therapists who were working in early childhood settings, but who were inadequately prepared to provide comprehensive family-centered interventions and highly sophisticated services for specific risk populations.

This competency-based interdisciplinary program was designed to address the developmental needs of practitioners from foundational skills to advanced practice competencies. A unique curriculum integrated academic learning and practical experience and, unlike most training projects, allowed therapists who were working to remain in the provider pool while enhancing their skills. Participants collaborated with project faculty and clinical supervisors in developing individualized learning contracts and received detailed feedback about their skill acquisition and achievement of targeted competencies.

Foundational Level therapists enrolled in a lecture series and completed an extensive supervised practicum. Training at the Enrichment Level included completion of a continuing education program involving didactic sessions and video tape case analyses. Advanced Level training addressed highly specialized competencies that required practicum experiences supervised by qualified practitioners. Follow-up activities for participating therapists included seminar meetings which emphasized faculty and peer review of assessment, treatment, and consultation problems encountered by participants in their practice. In addition, participants had access to extensive resource materials including a pediatric assessment library, videotape library, books, and relevant journal articles.

A comprehensive evaluation plan has been developed to monitor implementation, evaluate the appropriateness and effectiveness of programs in the development phases, and measure the achievement of project outcomes. During the third year of the project, faculty invited representatives from the lead agencies for P.L. 99-457 in six surrounding states and all OT

and PT training centers within the region to a training session to facilitate replication of this model program across the region.

Conclusions

1. Project activities described in the original grant proposal were successfully implemented and all goals and objectives were either met or exceeded. However, there were several shifts in emphasis based on participant need, evaluation data, and evolution of the model. Participant rates in extended practicums were less than anticipated and involvement in ongoing seminars exceeded expectations. The self study series, which was designed for individual use, was reconstructed as a group activity based on consistent and strong feedback that the issues needed to be discussed in interdisciplinary forums.

2. The use of an Individualized Learning Plan (ILP) resulted in the development of additional learning options and revealed that many practicing clinicians have learning needs that cross over the Foundational Level, Enrichment Level, and Advanced Specialization Level proposed in the original grant. The process of engaging practitioners in a collaborative process of designing programs simulated the Individualized Family Service Plan (IFSP) process. Not surprisingly, project faculty needed to establish credibility with participants about the wide range of options available in the program and facilitate the participants' active involvement in evaluating their strengths and needs and negotiating a feasible training option.

3. The movement toward the adoption of family-centered models of therapeutic services is highly complex. Unlike other approaches or technologies that have been adopted in a cumulative approach through the acquisition of new knowledge or techniques, embracing principles of family-centered care requires foundational shifts in therapists' frames of reference. This shift may require abandonment of some guiding principles. Additionally, other disciplines, parents, and program administrators need additional training in family-centered therapeutic models. We have found that organizational cultures and team expectations for therapists impeded the adoption of more innovative models of service delivery. We have found that organizational cultures and team expectations for therapists impeded the adoption of innovative models of service delivery that differed from traditional "expert" models.

4. The input of family members throughout all phases of the project substantially enhanced activities. As the project evolved, we expanded methods to incorporate the family perspective. Somewhat surprisingly, many therapists indicated that they did not have routine access to families to gather their perspectives in a reflective way. We also recognized that many parents were more comfortable with a model of participation that enabled them to selectively be involved with specific activities rather that commit to an ongoing role with limited definition of their potential contributions.

5. The model was organized around the development of partnerships with a broad range of individuals and agencies. Although the initial development of these partnerships was time intensive, we believe that these partnerships were pivotal to the success of the program and are the foundation for our ongoing activities at the termination of the funding period.

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IV. Goals and Objectives

The overall aim of this project is to improve the health and development of children in Illinois who have disabilities by increasing the provider pool of therapists who have the requisite knowledge, skills, and attitudes to provide comprehensive and effective early childhood intervention services. The specific goals and objectives are:

Goal 1. To develop, implement, and evaluate a comprehensive curriculum that promotes interdisciplinary collaboration, enhances therapists' abilities to provide family-centered interventions, improves the developmental outcomes of children, and enables therapists to design and implement cost-effective service delivery systems.

Objectives:
1.1 To identify the scope of content within each of the four curriculum domains: maximizing developmental outcomes, family-centered care, interdisciplinary collaboration, and innovative models of service delivery.
1.2 To incorporate learning experiences within the curriculum that enhance the therapists' self-awareness of attitudes and personal attributes that influence their decision-making and application of knowledge and skills.
1.3 To incorporate the perspectives of parents and other members of early childhood teams within each of the four domains.
1.4 To develop and integrate written and audio-visual training materials within the curriculum.
1.5 To design and implement a comprehensive evaluation plan that provides project faculty with feedback during development phases and measures project impact.

Goal 2. To provide a multi-level inservice training program for occupational therapists and physical therapists that integrates academic learning and clinical practice experiences.

Objectives:
2.1 To establish competencies for expected performance of Foundational Level, Enrichment Level, and Advanced Level therapists with input from the IAC and PAC.
2.2 To develop assessments of performance that are based on targeted competencies for each level.
2.3 To develop a menu of lecture offerings that address targeted competencies for Foundational Level therapists.
2.4 To design additional lectures to address any needs not fully met by existing lectures.
2.5 To develop and implement the curriculum for the Enrichment Level workshops.
2.6 To develop and implement the curriculum for Advanced Level therapists.
2.7 To develop and implement clinical practicum experiences at designated sites for Foundational Level and Advanced Level students.
2.8 To identify and secure commitments from additional clinical practicum sites as needed.
2.9 To design and produce video tape case analyses and accompanying written materials for self study component.
2.10 To develop and implement the follow-up seminar series.

2.11 To recruit and retain therapists to participate in all levels of training.
2.12 To provide on-going training and technical support to clinical practicum supervisors.

Goal 3. To incorporate mechanisms that will enable individual therapists to custom design the components of the training program that will most directly meet their professional development needs.

Objectives:
3.1 To implement the Individual Learning Plans.
3.2 To provide faculty advising to each therapist who applies to the program.
3.3 To distribute competency assessments to all participants.
3.4 To provide applicants with written feedback on their competency assessments.
3.5 To enable therapists whose needs cross over two or more training levels to obtain the specific training that they need.

Goal 4. To provide the representatives of state agencies and OT and PT curricula in neighboring states with training in the replication of the model and to disseminate curriculum materials.

Objectives:
4.1 To ensure that representatives receive information on the project during development phases.
4.2 To provide a training seminar that will enable participants to replicate the model within their state.
4.3 To disseminate detailed descriptions of the model training program and accompanying training materials.
4.4 To provide consultation to neighboring states regarding the implementation of the program as needed.

Goal 5. To integrate the training program within educational offerings at UIC to ensure that the program continues after the end of the funding period.

Objectives:
5.1 To facilitate the integration of Foundational Level students within the classroom and lab practicum settings.
5.2 To provide faculty, who are not directly involved with the program, with periodic updates on the implementation of the project and its impact within the professional community.
5.3 To identify opportunities to provide continuing education related to early childhood within future workshops offered by the department.
5.4 To develop mechanisms within the graduate program that will enable continual provision of Advanced Level clinical practicum experiences.

V. Theoretical Framework

The UIC Therapeutic Partnership Project (TPP) Model was developed to reflect our philosophy about "best practices" in early childhood for occupational and physical therapists. The following assumptions guided model development:

1. Central components to "best practice" are forming effective partnerships with children and families; recognizing, respecting, and integrating the perspectives of all team members; sharing the responsibility for service implementation; and using knowledge and applying skills in a cost-effective manner that maximizes developmental outcomes.

2. Enhancement of clinical reasoning abilities can be achieved in a learning context that provides facilitation of reflections on "daily dilemmas" in practice.

3. Therapists who are highly trained in biomedical models of practice, that often support reasoning processes designed to differentiate right from wrong and exactness in technical skill, may need additional training and support to develop a tolerance for ambiguity and a valuing of relativity in clinical decision-making.

4. Movement toward family-centered models of practice requires a foundational shift in the existing theoretical paradigms that guide practitioners.

5. Most existing frames of reference in occupational and physical therapy are child-centered and the process of adopting family-centered practices will necessitate the development of principles of family-centered care and the articulation of a conceptual framework that addresses the inherent complexities in occupational and physical therapy early childhood practices.

6. The success of the project is directly related to the quality of relationships and mutual interests identified through the development of partnerships with parents of children with special health care needs; representatives of related allied health, medical, educational, and social services disciplines; Part H coordinators; community-based programs; academic institutions; and leaders in occupational and physical therapy at the local, regional, and national levels.

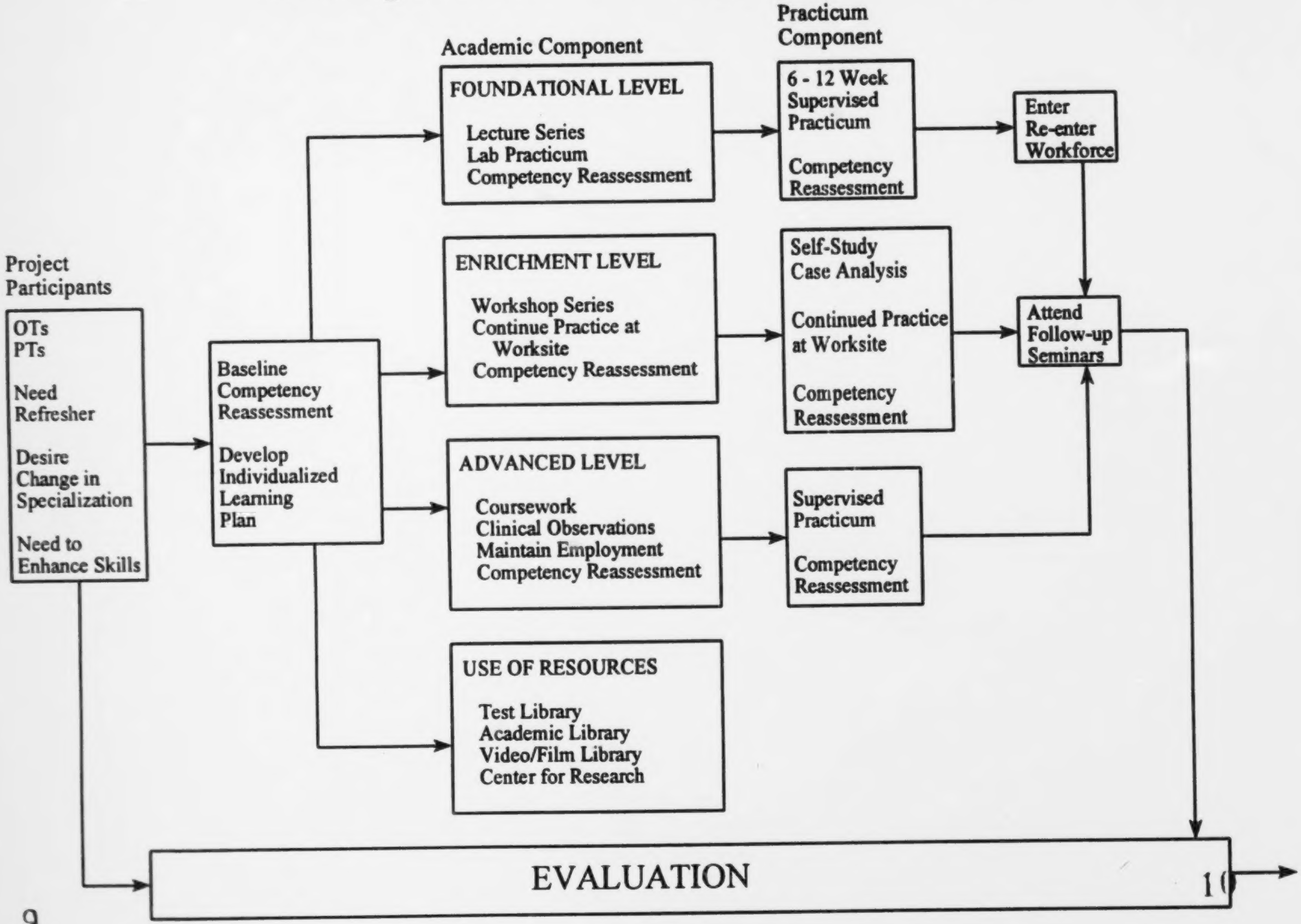
A schematic representation of the model is provided in Figure 1. The following sections describe key components.

Curriculum

We reviewed the extensive material available regarding professional standards for therapists, training needs, and necessary competencies for practice in early childhood intervention (e.g., AOTA, 1988a; AOTA 1988,b; Dunn, Campbell, Oetter, Hall, & Berger, 1989; Hutinger, 1981; Scull & Deitz, 1989; Gilfoyle, @1980; Knobeloch, 1987; Humphry & Hanft, 1989). We have identified four domains which have repeatedly emerged and will serve as the content base of the project curriculum. These are: 1) Designing and Implementing Family-Centered Interventions, 2) Maximizing Developmental Outcomes, 3) Interdisciplinary Collaboration, and 4) Innovative Models of Service Delivery.

FIGURE 1

Therapeutic Partnership Project Model



Designing and Implementing Family-Centered Interventions

Public policy strongly supports an intervention model in which the resources and needs of both the child and the needs of his/her family are central to early childhood programming. Within the framework of family-centered interventions, practitioners must take into account multiple factors which influence the therapeutic process in early childhood intervention. Activity patterns, roles, and relationships of each of the involved family members becomes important, and parental perceptions, needs, values, and expectations will considerably impact the outcomes of intervention (Bailey, 1988; Dunst, Trivette, & Deal, 1988). Services must enhance family resources for coping with a family member with an illness or disability and other stresses such as poverty (Zeitlin and Williamson, 1988).

The therapist involved in early childhood intervention must understand the complex dynamics which influence the decision-making process, and be able to establish effective partnerships with significant family members (Anderson & Hinojosa, 1984). Implementing this necessary family focus for all disciplines will be complicated by the fact that most therapists in early intervention programs have had little training in assessing family needs or providing family-centered services (e.g., Hanft & Humphry,1989; Latzko & Lawlor, 1988).

Maximizing Developmental Outcomes

Occupational therapists and physical therapists typically receive training in normal and abnormal development within their basic education (Hanft & Humphry, 1989). However, much of this information has become outdated. Over the past few years, researchers have revealed important findings on such practice-related topics as parent-infant interactions, environmental influences on developmental outcomes, behavioral organization in newborns, and patterns of motor development in premature infants. In addition, practicing clinicians are increasingly faced with emerging clinical problems in infants and children, such as sequelae of maternal substance abuse, ventilator-dependency, and HIV infections, for which they received little or no training.

Although therapists in practice report that their primary frame of reference for early childhood intervention is a developmental or neurodevelopmental theory of practice (Lawlor & Henderson, 1989; Heriza, Lunnen, Fischer, & Harris, 1983), clinicians are at a distinct disadvantage when attempting to integrate new information on infant and child development into their practice theories or learn about the implications of emerging clinical problems for occupational therapy and physical therapy. Continuing education programs have traditionally not addressed these needs, or have not presented research information in sufficient detail for therapists to gain the knowledge and skills that will result in improvements in practice. For example, therapists in Massachusetts recently rated their needs for continuing education on 33 early childhood topics. Physical therapists overwhelmingly rated research in early childhood development as the highest topic and occupational therapists selected this topic as their third highest area of interest (Latzko & Lawlor, 1988). This data provides insights into the changing training needs of therapists which are different than conventional beliefs.

Interdisciplinary Collaboration

As P.L. 94-142 implementation has progressed, therapists are finding increasing support for collaboration with teachers and other educational personnel. With the passage of P.L. 99-457, therapists are encouraged to further expand their collaborative efforts to include families. It is clear that genuine collaboration in determining the goals, objectives, and methodologies of interventions is most likely to result in favorable outcomes for children. As Effgen (1988) noted, "We must teach each others to teach the child. It is only through mutual cooperation and respect that we can help children achieve their best".

This new interdisciplinary model presents an exciting and challenging opportunity for therapists. A recent Illinois survey found that therapists strongly desired training programs which provide opportunities to observe other professionals, learn from other professionals, develop interpersonal skills needed for working on interdisciplinary teams, and gain experience as a member of an interdisciplinary team (McCollum and Thorpe, 1988). Clearly, therapists need and will benefit from inservice education which provides knowledge and strategies for more effective collaboration with partners in early childhood intervention.

Innovative Models of Service Delivery

Since most therapeutic practice is based on a child-focused direct service model, significant reorganization of the therapists' practice frameworks must occur so that therapists can better serve their consumers. Increasingly, therapists must assume roles other than that of direct service provider, such as consultant. Although the need for indirect and consultative service delivery models has been recognized for some time, recent surveys show that therapists are only assuming these roles in a very limited capacity (e.g., Lawlor & Henderson, 1989).

At UIC, we have studied the need to expand indirect and consultative models of practice (Bundy, Kielhofner, Knecht, & Lawlor, 1988) and have designed an innovative model for occupational therapy and physical therapy service delivery in school systems. Therapists who have attended recent presentations in Maryland, Minnesota, Illinois, Massachusetts, and New Mexico on the conceptual framework for the service delivery model have consistently reported that they need additional skills-oriented training in order to meet the demands for more consultative and indirect services. We have adapted some of the preservice training materials developed for the school system model and have incorporated some of these materials into out TPP model.

Professional Development Continuum

The model was designed around our belief that multiple options for training were needed to respond to the diverse needs of the target populations and to reflect our appreciation of the broad continuum of professional development characteristic of the professions of occupational and physical therapy. In addition, we strived to replicate the individualized family service planning process in our approach to identifying the strengths, resources, concerns, and needs of participants. To the extent possible, our collaborative efforts in addressing training needs were driven by the expectations and needs of participants.

Development of the Individualized Learning Plan

The core design of the model was structured around three levels of professional development that were conceptualized based on our knowledge of the profession, review of the literature, and pilot activities that were conducted prior to the submission of the grant application. The following descriptions summarize our conceptualization of the core needs at each level.

Foundational Level Training Needs

Therapists who enter early childhood intervention practice after a period of absence, typically require review of foundational knowledge, support to learn applications of new information, and guidance to assimilate the specialized perspectives and skills unique to therapy for young children and their families. Additionally, therapists who re-enter practice may bring additional abilities gained through life experiences or practices within other specializations that can contribute to their early childhood practice. Therefore, practicum experiences need to reflect adult learning models and may differ considerably from practicum experiences designed for students who are just beginning their careers.

Enrichment Level Training Needs

Therapists who have newly entered early childhood services cannot be assumed to have all the required specialized skills needed to practice in early childhood. They need training and support to enrich their basic professional foundation and to expand their specialty knowledge and skills. Therapists, who have been in practice for a number of years, received preservice education when little or information on families was available in their curricula. Pediatric occupational therapists currently practicing, on average, initially passed their certification examinations in 1976 (Lawlor & Henderson, 1989). Recent information in developmental psychology, assistive technology, and community-based practices are examples of the types of information that practicing therapists often need to obtain through inservice training.

Advanced Level Training Needs

Lastly, those therapists who work, or desire to work, with high risk populations (e.g., substance exposed, HIV infected), or in high risk practice environments (e.g., intensive care units), require advanced knowledge and skills. Existing approaches to continuing education have typically not addressed these advanced training needs of experienced therapists. Barriers to such training include the lack of qualified faculty, difficulty obtaining clinical practicum experiences, and the lack of qualified practitioners to serve as mentors.

Evaluation

The project was designed with evaluation activities as a central component of the model. Formative and summative evaluation methods were combined. Specific objectives of the evaluation plan were to ensure that: 1) the project was implemented in a timely and cost-effective manner; 2) unanticipated variations in the implementation process were identified and problems resolved; 3) feedback would be available throughout all developmental phases to enhance the overall quality of the project; 4) the scope and quality of the curriculum materials and their effectiveness were evaluated; 5) the achievement of project goals and short term and long term outcomes were measured; and 6) the extent to which the project impacted on the identified problem was assessed.

Self-Study

The primary purpose of the self study series was to provide therapists with an opportunity to work individually at their own pace and develop an Individualized Family Service Plan (IFSP) following the completion of exercises. These exercises were designed to promote reflections on their experiences with families and their tacit assumptions about how therapists should engage in the therapeutic process. We also hoped to address the needs of rural practitioners, who form a substantial portion of the manpower pool in Illinois.

Follow-up

We anticipated that therapists would need opportunities to discuss the application of new knowledge in their clinical practice settings. Follow up seminars in Year 3 of the project were designed to provide opportunities for therapists to discuss evaluation, treatment, interdisciplinary collaboration, and service delivery issues encountered in their practices. The model allowed the opportunity for therapists to video tape actual sessions or discuss cases in a seminar format that utilized principles of peer review combined with faculty facilitation. The purposes of these sessions were to provide: 1) feedback on therapists' application of knowledge, skills, and attitudes within their practice; 2) a forum for discussing emerging trends and recent research findings; and 3) a structure to sustain an interdisciplinary support network.

VI. Description of the Model

Competency Process

During the first six months of the project, we conducted a needs assessment through a comprehensive survey of occupational therapists and physical therapists who were licensed in Illinois. The purpose of this study was two-fold: 1) to describe therapists' perceptions of their competencies in early childhood, and 2) to evaluate the extent to which there were therapists who were either inactive or working in other specialties who could be recruited into early childhood. The sample was comprised of a randomly drawn sample of therapists who were currently licensed and a universe sample of all therapists who were categorized as licensed, but inactive, by the Illinois Department of Professional Regulation. Two hundred and seventy-six surveys were returned for an approximate response rate of 45%. A summary of findings is provided in Appendix J. A more detailed summary will be submitted to a professional journal for publication.

Project faculty reviewed existing competency statements, standards of practice, and the Illinois State Early Intervention Personnel Development Committee (EIPDC) recommendations for program development and personnel preparation for the implementation of P.L. 99-457. Project faculty also began delineation of specific program competency statements for each of the four primary curriculum content areas. The faculty established competencies and identified the content for each of the domains. The competency statements were purposely written to reflect the primary areas of expertise that are necessary for effective practice in early childhood. The number of statements was kept to a minimum to reflect the core target areas of the project. Copies of these competency statements are provided in Appendix A

Project faculty recognized the limitations of competency statements in describing optimal attributes of an early childhood practitioner. We spent considerable time addressing the question of how we could best describe the type of person that we would most want to practice with young children and their families. These discussions generated a descriptive list of attributes entitled: "The Competent Therapist." We have found this aspect of the model to be particularly helpful in talking to therapists about therapeutic use of self and the development of effective partnerships with parents. The list is included in Appendix B. A policy statement regarding faculty advising was also developed and is provided in Appendix C. As the project evolved the mode of faculty advising changed considerably with greater emphasis on the participant role in developing and enacting learning plans. In many ways, faculty advising became more participant driven.

The Interdisciplinary Advisory Committee (IAC) was formed within the first months of the grant. The members of the IAC were as follows: Margaret Aylesworth, MA; Ellen Berger, MS, OTR; Richard Brinker, PhD; Sue Covern, RD; Deborah Gaebler-Spira, MD; Linda Gilkerson, PhD; Linda Groetzinger, MA; Thubi Kolobe, MS, PT; Tink Martin, MACT, PT; and Marlene Morgan, MS, OTR. The Interdisciplinary Advisory Committee (IAC) met on February 8, 1991.

The IAC reviewed the competencies and gave their feedback for each of the three designated levels. In addition, suggestions for the development of the curriculum and recommendations for speakers were given. The IAC supported the issue of the importance of therapist recruitment. They suggested aggressive marketing to pediatric facilities and academic programs. They also supported plans to redesign the Parent Advisory Committee (PAC), as they felt that greater parental involvement would strengthen the project. The IAC supported the concept of input from all disciplines on the intervention team as essential. They felt that team organization was a critical issue. Many of the suggestions from the IAC were incorporated into the competencies. In addition, the IAC recommended a modification to "The Competent Therapist." Number seventeen, "takes care of oneself," was added. A lengthy discussion was held regarding the lack of emotional supports and use of mentors in the professional cultures of occupational and physical therapy. This issue has become increasingly apparent throughout the project and is considered to be a major need within both professions. In addition, we have been contacted by a number of therapists who are looking for assistance in exploring career options as they age and worry about their abilities to continue to meet the physical demands of practice.

The Parent Advisory Committee (PAC) was established and was initially comprised of eleven parents who had a child with a disability and experience with occupational and/or physical therapy services. Over the course of the project, additional parents joined the advisory committee. These individuals expressed an interest and willingness to participate in a number of different ways. Types of involvement included: being interviewed; reviewing curriculum materials; providing training for all three levels of participants; and developing training materials including the video tape series. Members of the PAC were also asked to participate in the Enrichment Level Workshops and Seminar Series. The family perspectives and their willingness to participate in all project activities has been extremely valuable. A copy of the PAC report that was completed at the end of Year 1 can be found in Appendix D.

Professional Development Continuum

The training program was designed to meet the professional development needs of three identifiable levels of practitioners:

1) Foundational Level training addressed the needs of occupational and physical therapists who wished to enter early childhood intervention practice after a period of absence or who desired to change their area of specialization and enter early childhood practice. These therapists typically required review of foundational knowledge, support to learn applications of new information, and guidance to assimilate the specialized perspectives and skills unique to therapy for young children and their families. Foundational level training provided therapists, who were not working or who were working in another area of practice, with the skills needed to enter the work force in early childhood.

2) Enrichment Level training provided therapists who were working in early childhood with the skills needed to improve the quality and scope of early childhood intervention services. Therapists who have newly entered early childhood services cannot be assumed to have all the required specialized skills needed to practice in early childhood. They need training and support to enrich their basic professional foundation and to expand their specialty knowledge and skills. Therapists who have been in practice for a number of years received preservice education when little or no child and family information was available in their curricula.

3) Advanced Level training was designed to meet the needs of therapists who worked, or desired to work, with high-risk populations (e.g., substance exposed, HIV infected), or in high risk practice environments (e.g., intensive care units). Existing approaches to continuing education have typically not addressed these advanced training needs of experienced therapists. Barriers to such training include the lack of qualified faculty, difficulty obtaining clinical practicum experiences, and the lack of qualified practitioners to serve as mentors. This program provided advanced training and supervised practicum experiences to therapists in order to prepare them to meet the specialized needs of high-risk populations.

Many of the participants crossed levels and few therapists identified themselves as "experts." During the initial recruitment for mentors for the advanced specialization level, we were surprised by the statements of a number of therapists who felt that they weren't experts and who wished to receive training before mentoring others. This was not unlike the findings on the needs assessment in which the majority of the self ratings were in the "some" skills to "adequate" skills range as opposed to "good" or "excellent ranges." We believe that these ratings of self competence represent, in many cases, confounding of self confidence and perceptions of competence. Throughout the project, we were also impressed with the numbers of therapists who received little routine feedback about their performance and who lacked access to more experienced therapists or peers who could discuss problems with them.

Development of the ILP

The primary vehicle for establishing collaborative efforts with prospective participants was the Individualized Learning Plan (ILP). A copy is provided in Appendix E. When individuals expressed interest in the project, they met with a faculty advisor to discuss their needs and potential options provided through the model. Guidelines for the advisory process are provided in Appendix C. The model options were expanded whenever the project could not address the needs of individuals with existing options. Therefore, components of the model were somewhat fluid and the project took on a more dynamic nature than predicted in the original application.

The project faculty reviewed the Individual Learning Plan (ILP) and initiated recruitment and interview activities. A copy of the ILP is in Appendix E. The faculty also completed a progress sheet with all trainees to keep track of accomplishing goals. The ILP was used with each participant. The goals and objective were set with periodic evaluations.

Participants at the Enrichment Level, who did not opt for practicums, completed portions of the ILP through the use of Evaluation Form A. These participants did not engage in an ongoing faculty advising process, though many had periodic contact with project faculty.

Individual Participants

Over the three year period there were 37 therapists enrolled to receive individual faculty advising. Each participant completed the ILP and met with their faculty advisor to design their program. Table 1 summarizes participants. Twenty-two participants completed practica or on-site training.

TABLE 1
TPP Participants Who Received Faculty Advising

Participant's Initials	Discipline	Start Date	Practicum	Workshops	Seminars
LA	SLP	11/92	X		
JA	OT	1/92	X	X	
CA	OT	11/93			
LB	PT	4/93	X		X
LB	OT	3/92	X	X	X
DB	OT	9/91	X		
CB	OT	10/92		X	X
MB	OT	11/90	X	X	X
VD	PT	11/92	X		X
JD	SLP	11/92	X		
CF	OT	12/92			X
JG	PT	11/92	X		
RH	OT	4/92	X	X	X
KH	OT	9/92			X
BK	OT	8/91		X	X
MK	OT	9/91			
CHL	OT	4/92		X	
KL	PT	11/92	X		X
SM	PT	11/92	X		
DM	OT	8/91		X	X
BM	OT	5/91	X	X	X
CM	OT	7/91	X		
DMc	OT	8/93	X	X	X
JO	OT	5/92		X	X
JP	OT	9/92		X	
BP	PT	11/92	X		
EP	OT	8/91			
GR	PT	11/92	X		X
CS	OT	10/92			X

Participant's Initials	Discipline	Start Date	Practicum	Workshops	Seminars
ES	OT	9/92	X	X	
GS	OT	9/91			
AS	PT	6/92	X	X	X
CS	PT	11/92	X		X
JS	OT	3/91			
MES	OT	3/92		X	
DT	OT	4/91	X		X
ST	PT	12/90	X		

Curriculum

The primary components of the curriculum were practicum experiences conducted during Year I, Year 2, and Year 3; the Enrichment Level Workshops conducted during Year 2; the follow-up seminars conducted in Year 3; the self study series; coursework; and resource library.

Practicum Experiences

Table 2 summarizes the practicum sites. The Fieldwork Coordinator reviewed the ILPs and discussed the learning objectives with the faculty advisor and participant. She contacted prospective sites, arranged introductions, and provided consultation to practicum supervisors regarding the adoption of adult learning models for supervision. In addition, the Fieldwork Coordinator facilitated performance reviews and assisted with problem resolution as necessary. In general, therapists expressed high degrees of satisfaction with the practicum component of the model. Twenty-two individuals participated in a practica. Occasionally, participants expressed the desire for additional training. In one case, the participant terminated her practicum experience due to her belief that the setting and available populations and practice options did not meet her needs. At least three TPP participants were hired for permanent staff positions at the conclusion of their training period.

TABLE 2
Practicum Sites

Practicum Sites	Type	# of Participants
CASE (Cooperative Association for Special Education)	School	2
Childrens Memorial Hospital	Hospital	2
Mercy Hospital/Medical Center	Hospital	2
Lutheran General Hospital	Hospital	1
Mary Massery (PT)	Consultant	1
DuPage Easter Seal	Community	2
Resurrection Hospital	Hospital	9
Pediatric Place	Community	1
NAPRE (National Association of Perinatal Research and Addiction)	Community	1
Kids in Motion	Community	1
University of Illinois Hospital	Hospital	2
Sensory Integration Observations	Course Work	1
Early Childhood Center, Northfield	Community	1

Year-Two Enrichment Workshops

Four two-day workshops were held during the spring and summer of 1992. Each workshop was designed around one of the four primary content domains. Extensive reading materials and supporting documents and worksheets were provided with each workshop.

The workshop schedule was **Making It Work: Family Oriented Intervention**: February 25-26, 1992. Speaker for this workshop were Mary Lawlor, Beth Cada, Linda Groetzinger, Anita Bundy, Scott Azuma, Ellen Berger, Deborah Walens, Melissa Stabrawa, Jamie Gordon and Mary Black. There were 54 participants at this workshop.

Maximizing Developmental Outcome: Nurturing Environments: April 30- May 1, 1992. The speakers were Mary Lawlor, Clare Curtin, Margaret Aylesworth, Ann Grady, Beth Cada, Scott Azuma, and Robert Almli. There were 40 participants.

Colleagues as Partners: Interdisciplinary Collaboration: May 21-22, 1992. Speakers included Mary Lawlor, Deborah Walens, Fran Abramson, and David Rosenblatt. There were 45 participants.

Is There a Better Way?: Innovative Models of Service Delivery: June 25-26, 1992. Speakers included Drew Akason, Theresa O'Shea, Linda Colson, Mary Black, MaryAnn Witvoet, Sue Iacovelli, Abby Baxter, Don Gabard, Melissa Stabrawa, Mike Brady, Eileen Thomas, Sharon Drazner, Stacy Jones, Lynn Hyatt, Fran Abramson, Mary Lawlor, Mary Massery. There were 45 participants.

These four workshops represented a total of 156 individual participations from a variety of disciplines. Approximately one third of the participants attended all four of the workshops while some attended those which were most pertinent to their practice. A summary is provided in Table 3.

TABLE 3
Workshop Participants

Participants	Discipline	Workshop 1	Workshop 2	Workshop 3	Workshop 4
01-12-05	OT	X	X	X	X
01-12-12	OT	X			
01-14-04	PT	X	X	X	X
18-15-02	Other	X		X	X
02-01-18	OT	X	X	X	X
02-09-03	OT	X		X	X
02-09-05	OT	X			X
03-01-08	OT	X		X	X
03-01-13	PT	X		X	X
03-09-15	PT	X	X	X	X
03-15-15	OT	X		X	
03-15-19	OT				X
03-21-14	OT	X	X		X
04-01-18	OT	X	X		
04-09-05	OT	X	X	X	X
05-19-05	OT	X			X
07-01-12	OT	X			X
07-18-01	PT	X	X	X	X
08-01-18	OT	X		X	X
08-15-23	OT	X		X	X
09-04-05	OT	X	X		X
10-01-03	OT	X		X	X
07-23-05	PT	X	X	X	X
10-15-08	Other	X	X	X	X
11-01-03	OT	X			
11-01-04	OT				X
11-01-05	OT				X
11-15-18	OT	X	X	X	X
11-18-01	RN			X	
12-01-22	Other	X			
12-05-05	OT	X		X	X

Participants	Discipline	Workshop 1	Workshop 2	Workshop 3	Workshop 4
12-25-14	OT	X		X	X
12-25-15	PT	X			
13-03-07	OT	X	X	X	X
13-03-13	OT	X	X	X	X
13-03-14	OT	X	X		
13-01-14	OT	X	X	X	
18-15-20	OT	X	X	X	X
13-01-18	OT	X		X	
15-05-19	OT				X
14-05-23	OT	X	X	X	
14-09-03	PT			X	X
08-09-18	OT				X
12-01-09	OT			X	
13-01-07	OT			X	
14-15-18	OT	X			
15-12-19	OT				X
16-01-20	OT	X	X	X	X
16-05-19	PT	X	X	X	X
16-15-13	Other	X	X	X	X
17-21-09	OT			X	
18-05-19	OT				X
18-15-13	PT	X	X		
19-01-14	OT	X		X	X
19-01-15	OT	X	X	X	X
19-13-09	PT	X			
19-20-05	OT	X			
19-23-01	OT	X			X
20-08-15	Other	X			
23-01-07	OT	X		X	X
23-01-12	OT	X	X	X	X
23-05-09	OT	X			X
23-09-14	OT	X			X

Achievement of designated competencies related to gaining new knowledge and skills and evaluating attitudes was measured through pre and post workshop questionnaires. These questionnaires and evaluations are found in Appendix F. Information from these evaluations was used for the basis of a graduate thesis: Perceived Changes in Practice Following Training in Early Childhood, for completion of a masters of science degree in Occupational Therapy at the University of Illinois, at Chicago.

Follow-up Seminars

During year three, 19 follow-up seminars were conducted. The purpose of the seminars was to provide: (a) feedback on therapists' application of knowledge, skills and attitudes within practice; (b) a forum for discussing emerging trends and recent research findings; and (c) a structure to sustain an interdisciplinary support network. The seminars were open to all participants of the project as well as local therapists interested in the topic of the meeting. Several of the seminars were conducted by outside speakers such as:

> Winnie Dunn, PhD, OTR, University of Kansas, presented "Interdisciplinary Collaboration".
>
> Elizabeth Devereaux, MSW, ACSW/L, OTR/L, FAOTA, Medical College of West Virginia, presented "Family-Centered Care: Change Makes Waves".
>
> Patti Ideran OTR/L, Pediatric Rehabilitation Services, presented the "Peabody Developmental Motor Scales".
>
> Susan Stahlings-Sahler MS, OTR/L, National Association for Perinatal Research and Education, presented "The FirstStep Screening Test for Evaluating Preschoolers and the New Bayley Scales of Infant Development".
>
> Andrea Fouchia OTR/L, Mercy Hospital, and Debbie Anderson MS, PT, Pediatric Rehabilitation Services, presented "Curriculum-based Assessments" (i.e. the HELP, Battelle Developmental Inventory, Carolina Curriculum for Handicapped Infants and Infants at risk).
>
> Suzann K. Campbell, PT, PhD., University of Illinois at Chicago, presented information about the "Test of Infant Motor Performance" (T.I.M.P).
>
> Joy Browne, PhD, RN, Denver Childrens' Hospital, presented a full day on the developmentally supportive care for the neonate.

There was a four part series conducted by project faculty entitled: **Making Your System Work For You**. The topics explored were how to assess readiness for change, can you change a system, and how to implement change. The other sessions were organized around three other series: Issues in Assessment; NICU Care and Medically Fragile Infants; and Family-Centered Practices. There were 135 participants throughout the seminar series. Patterns of attendance are provided in Table 4, Appendix K.

Although we had originally planned on only conducting bimonthly seminars in Year 3, we substantially expanded this component of the model due to the huge success and multiple requests that we continue. These seminars provided a learning option not readily available to practicing clinicians and proved to be a successful forum for promoting reflections on everyday practice dilemmas. We also used the discussions to promote therapists' comfort with ambiguity and to demonstrate the importance of aspects of practice typically relegated to "underground practice" (Mattingly & Fleming, 1994). These components included developing relationships, understanding the meanings of illness and disability, communication, interdisciplinary functioning, ethical dilemmas, and consultation.

Self-Study

Beginning in Year 2 of the project the Parent Advisory Committee Report was analyzed for themes and stories. From this information, a group of graduate students and project faculty including parents met on a monthly basis to develop a script for a three video-tape self study series. Several significant decisions were made during the development of the script. The group felt that having actors portray the story would be much less intrusive than asking a family to be filmed. We recruited various colleagues and members of our own families to complete the cast.

This dramatic portrayal of family life allowed the group to incorporate many of the stories and issues families shared during the interview process. We drew heavily on the stories of families to ensure that the types of events portrayed in the family scenes reflected scenarios that would seem familiar to many therapists and families. The development of the script involved several months of regular weekly meetings, and time to allow for reflection by both the professional and family members involved in the process.

After the script was fully developed, actors selected, and locations scheduled, the filming took four days. The first level of editing was completed and the video series was shown to several focus groups that included therapists, therapists and families, and families. The feedback from the focus groups allowed the staff to check the validity of the story and gauge the realism. All the information was incorporated and the final edits were completed by the Office of Media Services at UIC.

Once the video-tapes were completed another group of individuals met with an instructional design consultant to put together a workbook to accompany the video-tapes as stated in the goals for the project. The workbook was originally designed to be used by individuals as a self study course. After using the video-tapes in a group at the dissemination meeting it was changed slightly to suggest that the participant view the tapes with a colleague or a partner. A copy of the workbook is provided in Appendix G and was designed with an answer booklet to be returned to the university for feedback. The feedback is to be given on the reasoning process rather than on the correctness of the answer. At the time of writing this report, we have primarily used the videotapes with small groups and only a handful of therapists have completed the series on a self study basis. Additional information on this modification in the model is provided below.

A facilitator guide is currently being developed to accompany the videotapes when used in a larger group. The purpose of the guide is to sensitize facilitators to issues that may warrant further discussion, and to provide strategies to promote participant reflection on major themes.

Coursework

During the summer of 1993, the third year of the project, project faculty collaborated with Linda Gilkerson, PhD, Fran Stott, PhD, and Therese Wheman, MS, at the Erikson Institute to co-teach two courses in an early intervention series. One was an assessment course and the other on intervention. The courses were held at Loyola University, Chicago. Each course met once a week, for seven weeks from June through August. TPP faculty were responsible for specific content of each course as well as supplemented material presented by the faculty. These courses were a collaborative activity among UIC Therapeutic Partnership Project, Erikson Institute, and the University of Illinois, Urbana-Champaign Partnership Project. In addition, attendance was supported by P*TEIS (an OSERS sponsored personnel partnership preparation grant, P.I. Dr. Jeannette McCullom).

These projects sponsored 3 TPP individual participants, enabling them to take the course(s). One participant was a Foundational Level trainee, who was wanting more information and skills to work with pediatrics to change from her field of psychology. Another trainee was an Advanced Level trainee, who wanted to begin to acquire the prerequisites for early intervention certification for the state of Illinois. The third student was taking the course to fulfill a graduate school requirement, as she also is changing her area of practice.

Over the course of the three years, four therapists enrolled in courses at the university as part of their ILP. Two additional participants received support to take continuing education courses at other settings. Three participants enrolled full-time in the graduate program.

During Year 2 of the project Dr. Lawlor collaborated with Dr. Cheryl Mattingly in the development and implementation of a graduate level course entitled : "Family-Oriented Approaches to Intervention. Dr. Mattingly, who is a medical anthropologist, is an internationally known expert in the field of clinical reasoning and narrative approaches to understanding the phenomenology of experience. Five enrolled graduate students and five members of the clinical community took the course. The course evaluation revealed very high degrees of satisfaction.

During Year 3, Dr. Lawlor offered a graduate course entitled "Daily Dilemmas in Clinical Practice." Only one graduate student is enrolled for course credit, but fifteen members of the clinical community have registered for a four part seminar series modeled after the TPP evening seminar series. The majority are occupational therapists, but participants include representatives from physical therapy and speech and language therapy.

Resource Library

An indirect development from this grant was the expansion and use of the Maternal and Child Health Library (MCJ #9101). This library consists of books, articles, videos, and pediatric tests. This library was available for TPP participants' use throughout the course of the grant. As the library was utilized it became clear what new materials were needed. The materials were purchased through the funding of the MCH grant, but clearly demonstrates the ability and benefit to use multiple resources to accomplish goals.

Evaluation

The evaluation plan incorporated multiple data collection strategies. As the project evolved and the numbers of options for participants were expanded, we began incorporating more open-ended, focus group, and qualitative data collection strategies. We recognized that we needed more indepth information about the impact of the project on individuals and needed to gather additional insights about the complexity of the move toward family-centered care.

We collected data at the following intervals: 1) when individuals who desired faculty advising enrolled in the program; 2) pre and post each of the four workshops; 3) approximately three months after the dissemination workshop; 4) course evaluation summaries; and 5) final impact study initiated two months after the completion of the project. Portions of the final impact study are described below in findings. However, we are still receiving mailed questionnaire forms back from recipients at the time of the writing of this report.

In addition, project faculty met periodically to discuss implementation issues and feedback received from participants. We encouraged participants and others interested in the project to contact us when there were issues that they wanted to discuss. This periodic and spontaneous feedback was also used to evaluate implementation and shape the project.

Public Service

We have worked closely with a number of community agencies and professional organizations throughout the course of the project. The following list summarizes key activities:

1. Dr. Lawlor has served as a member of the Early Intervention Personnel Development Committee (EIPDC) for the state of Illinois for the past three years and continues to serve as a member. In addition, Dr. Lawlor and Ms. Cada have served on several Ad Hoc personnel committees convened by the Erikson Institute, Chicago, Il.

2. Dr. Lawlor and Ms. Cada have provided inservices related to the TPP project at the following agencies: Blue Cap Early Intervention Program, Blue Island, IL; Children's Hospital Medical Center, Chicago, IL; Mercy Hospital, Chicago, IL; Rehabilitation Institute of Chicago, Chicago, IL; Developmental Pediatrics Conference at Southern Illinois School of Medicine, Springfield, IL; University of Illinois Hospital, Chicago, IL; Carle Memorial Hospital, Champaign; IL; Erikson Institute, Chicago, IL; Illinois Association for Infant Mental Health, Wilmette, IL; Chicagoland Pediatric Special Interest Section, Chicago, IL; American Occupational Therapy Association, Rockville, MD; Boston University, Boston, MA; Chicago Lighthouse for the Blind, Chicago, IL; and Resurrection Hospital, Chicago, IL .

3. Ms. Cada serves as a member of the Dupage County Early Intervention Interagency Coordinating Council.

4. Dr. Lawlor is a member of the national Pediatric Specialty Certification Board and the Pediatric Standards of Practice Committee of AOTA. Ms. Cada is President of the American Occupational Therapy Certification Board.

5. Ms. Cada serves on the Board of Directors for the Ray Graham Association and is Chair of the Program Audit Committee. Dr. Lawlor has begun meeting with the Advisory Board to the Illinois Center for Rehabilitation and Education, Chicago, IL.

6. The project has provided advice and technical assistance to approximately 15 therapists who are applying for credentialing as an Infant Specialist in the State of Illinois.

7. Project faculty have met separately with faculty from England, Denmark, and Sweden to discuss the project and share information regarding preparing professionals for family-centered care. In addition, Ms. Vicki van Rensburg, West Cape Town, South Africa was a Visiting Scholar who studied with Dr. Lawlor through a Ford Foundation grant.

8. Project faculty have provided information on the model to faculty in two other programs who were seeking funding to support early childhood training.

VII. List of problems and resolutions

The project was implemented as intended with only minor revisions and the project met or exceeded the goals and objectives. However, as the project evolved several aspects changed and some activities received greater emphasis than originally proposed. The dynamic nature of the project also resulted in some unanticipated shifts in activities and personnel. The following section provides a discussion of these shifts in emphasis and personnel.

Faculty Changes

Tables 5 and Table 6 provide a summary of the allocation of personnel throughout this three year interdisciplinary project. At the end of Year 1, Dr. Russ Carter, physical therapy faculty, and during Year 2, Dr. Anita Bundy, occupational therapy faculty, resigned from UIC. Their positions were filled by faculty who were familiar with the project. The Project Manager and Project Coordinator positions were also changed at the end of Year 1. The numbers and types of consultants expanded dramatically as the project took shape. As discussed below in the findings, the need to broaden the family perspectives and involve representatives of other educational and allied health disciplines lead to this expansion.

TABLE
Allocation of Personnel

Title/Name	YR 1	YR 2	YR 3	Responsibilities	Expertise
Project Director Mary Lawlor	X	X	X	Overall execution and quality of the project, directing conceptual development, designing and overseeing evaluation activities, project faculty	Project management; infant and child development; family systems; interdisciplinary collaboration; early intervention
Project Manager				Developing detailed action plans, coordinating all project activities, completing arrangements for all educational programs, recruitment of participants	Organization of daily operations, representation of project
Scott Azuma	X				
Elizabeth Cada		X	X		
Project Coordinator				All clerical and communication functions to support the project	Organization of daily operations, grant budgets, and data processing
Kristen Kobe	X				
David Parkes		X	X		
Project Faculty				Develop curriculum; provide lectures; teach workshop content; advising participants; developing competencies; competency assessment; design and implement follow-up seminar	Play, occupational roles, SI, NDT, models of service delivery, curriculum design, pediatric interventions, efficacy of treatment
Anita Bundy (OT)	X	X			
Russell Carter (PT)	X				
Melissa Stabrawa (PT)		X	X		
Patty Ideran (OT)		X	X		
Annette Smith (PT)		X	X		
Peggy Metzger (OT)			X		
Fieldwork Coordinator				Training of clinical supervisors; placements of therapists; maintaining communication with sites; on-site visits; fieldwork performance evaluations	Models of supervision, effectiveness of clinical practicums, specialty training
Deborah Walens (OT)	X	X	X		
Melissa Stabrawa (PT)		X	X		

Title/Name	YR 1	YR 2	YR 3	Responsibilities	Expertise
Consultant Media				Consultation regarding design of audio visual materials; oversee all production	Instructional technology, adult learning
Thomas Maher	X	X	X		
Corey Cather	X	X	X		
Susan Applegate	X	X	X		
Bill Biagi		X	X		
Hans Brendel		X	X		
Liaison to PAC Elizabeth Cada	X	X	X	Coordinate the appointment of parent advisory council members	Leadership in parent and professional organizations

TABLE 6
Project Consultants

	IAC	Workshop Speaker	Seminar Speaker	Video Series	Fieldwork Supervisor
Fran Abramson (Parent)	X	X		X	
Drew Akason (Other)		X			
Robert Almli (OT)		X			
Debbie Anderson (PT)		X			
Margaret Aylesworth (MA)	X	X			
Scott Azuma (PT, PhD)		X			X
Abby Baxter (ECRIP)		X			
David Beer (Anthr.)				X	
Ellen Berger (OT)	X	X		X	
Mary Black (OT)		X		X	
Mike Brady (DSCC)		X			
Richard Brinker (PhD)	X				
Joanne Bristol (OT)					X
Joy Browne (PhD, RN)			X		
Suzann Campbell (PT)		X			
Linda Colson (EI)		X			
Paula Costello (OT)					X
Sue Covern (Other)	X				
Lori Cox (OT)					X
Kate Crowley (OT)				X	
Clare Curtin (OT)		X			
Tim Davies (Other)				X	
Elizabeth Devereaux (OT)			X	X	
Sharon Drazner (Parent)		X			
Winnie Dunn (OT)			X		
Andrea Fouchia (OT)			X		X
Diane Fritz (OT)					X
Don Gabard (PhD, PT)		X			
Deborah Gaebler-Spira (MD)	X				
Linda Gilkerson (PhD)	X				
Jamie Gordon (OT)		X		X	

	IAC	Workshop Speaker	Seminar Speaker	Video Series	Fieldwork Supervisor
Ann Grady (OT)		X			
Marty Gram (PT)		X			
Linda Groetzinger (MA)	X	X			
Stephen Haley (PT)		X			
Carolyn Heriza (PT)		X			
Lynn Hyatt (Parent)		X			
Sue Iacovella (EI)		X			
Patty Ideran (OT)		X	X		
Stacy Jones (Parent)		X			
Thubi Kolobe (PT)	X	X	X		
Maureen Lemke (OT)					X
Tink Martin (PT)		X			
Liz Maruyama (OT)				X	
Mary Massery (PT)					X
Peggy Metzger (OT)		X		X	
Marlene Morgan (OT)		X			
Theresa O'Shea (DD)		X			
David Rosenblatt (Parent)		X			
Annette Smith (PT)		X		X	X
Melissa Stabrawa (PT)		X			
Susan Stahlings-Sahler (OT)			X		X
Eileen Thomas (Parent)		X			
Debbie Wallenberg (OT)					X
Debbie Whalens (OT)		X		X	
Gwen Williams (OT)		X		X	
Mary Ann Witvoet (ITAP)		X			

Changes in Participants

As the project evolved, we encouraged occupational therapy and physical therapy participants to invite other members of their teams to workshop and seminar activities and to participate in training sessions using the video series to promote team approaches to family-centered care. Gradually, members from other disciplines began to attend these sessions. Table 4, Appendix K, provides a summary of the interdisciplinary nature of the seminar series.

Although we had anticipated equal distribution of occupational therapists and physical therapists throughout all project activities, we found greater interest and levels of participation in the occupational therapy community. Responses from the physical therapists who did participate were generally highly positive and some of the most "dramatic" feedback came from this group (e.g., "You have changed my life").

In order to promote additional interest in the physical therapy community, we conducted an additional workshop. On March 12, 1993, TPP, the Department of Occupational Therapy, and the Department of Physical Therapy co-sponsored an education conference: **Clinical Assessment of the Pediatric Client**. The purpose of the conference was two-fold: 1) to provide a continuing education opportunity for pediatric physical therapists in a tri-state area centered around Chicago as part of the TPP; and 2) to increase visibility and publicity of the Therapeutic Partnership Project to physical therapists.

Invited speakers were Stephen Haley, PhD., PT, Carolyn Heriza, Ed.D., PT, and Marty Gram, PT. An additional member of the discussion panel was Thubi Kolobe, PhD.,PT. and Melissa Stabrawa, MS, PT moderated the conference. The conference was attended by 100 participants the vast majority being physical therapists with a few occupational therapists in attendance.

We also had anticipated that more individual participants who sought faculty advising would develop collaborative learning plans that involved lengthy practicum experiences. Although 22 participants completed practicums, we found that the practicums were for shorter duration than our original projections. Many participants selected workshop, seminar, or coursework experiences over practicum experiences.

Resurrection

Resurrection Medical Center contacted the UIC TPP project expressing interest in participation in this project. They were interested in expanding their pediatrics program and developing some type of follow-up program for the Level II nursery. They had a supportive neonatologist and some pediatricians who would be willing to refer children to them. They had one physical therapist and one speech therapist who were currently seeing a small caseload of children and seeing some of the high risk infants in their Level II nursery. The physical therapist was a new graduate who had done a pediatrics clinical affiliation. They had one additional physical therapist and one additional speech therapist who were interested in pediatrics. Other interested staff members were interested only in gaining enough confidence to provide coverage for the pediatrics staff.

It was decided by Mary Lawlor, Project Director, and Beth Cada, Project Manager, to pursue this interest by setting up an on-site training program. Initial meetings with Dr. Lawlor, Ms. Cada and the Resurrection Medical Center physical medicine administration proved that both parties were extremely interested in setting up an on-site training project.

The participants included seven physical therapists and two speech therapists. (The occupational therapy department was not directly involved with the hospital pediatric program.) In December 1992, Patti Ideran, a project faculty member, and Ms. Cada interviewed all interested participants. The participants had completed ILP's prior to the interview, and their learning objectives were reviewed and refined during the interviews. Upon completion of the interviews priorities were determined. Overall, the participants were interested in improving their knowledge in the following areas (in order of priority): assessment in the NICU; follow-up in the NICU; utilizing the team approach (improving communication); treatment in the NICU; role delineation in the NICU; documentation; parental involvement; and community resources. In May of 1993, a memorandum of understanding was written between Resurrection and the University of Illinois at Chicago. Several meetings and discussions between TPP Project faculty and the participants at Resurrection determined a general plan to initiate the training program. This plan included the following: inservice training by project faculty; inservice training by consultants; inservices by participants; study groups; participation in TPP evening seminar series (on NICU and assessment); observation of experienced therapists during treatment; consultation to treatment provided at Resurrection; and clinical practicums.

The on-site training was provided by Patti Ideran and Annette Smith, project faculty. The programs were held late in the day or during the staff lunch times to minimize disruptions in the therapists' schedules. The hospital administration agreed to provide the necessary meeting space and to allow the therapists time to attend the 2-hour programs two times per month. Students rotating through the therapy departments were also welcomed to attend the inservice programs. The program topics were: normal development; abnormal development; observation of normal posture and movement patterns; facilitation of movement; and instruction in the administration and use of the Movement Assessment of Infants.

The physical therapist who was responsible for seeing infants in the nursery spent part of a day with a therapist at Central DuPage Hospital (CDH). CDH has a Level II nursery and therapists provide services to the infants in the nursery. They have developed assessment and treatment protocols and have a follow-up program to monitor infants after they are discharged from the nursery. These protocols were shared with the Resurrection physical therapist. Annette Smith, project faculty, observed a treatment session with one of the Resurrection physical therapists. Other participants were also observed. Information was shared among all participants. Three of the Resurrection staff attended several of the NICU and the assessment series seminars that were held at UIC.

During the time that the TPP staff was providing the on-site training, many changes were occurring in the hospital administration, and there were a significant number of staff changes. Only one of the original administrators and two of the original staff participants were still on staff at the hospital when the project ended. One staff member left because she wanted to work full-time in pediatrics.

VIII. Findings

Model Design

It was found that throughout the project the overall design worked well. The three training levels identified (i.e., foundational, enrichment, and advanced) encompassed the needs of the therapists who became involved in the project. It became clear that the levels were not mutually exclusive. There were therapists whose needs spanned the range of levels. This was more clearly recognized after the ILP was completed and the individual met with their advisor and mentor.

Therapists in the beginning had difficulty truly believing that they were in control of their learning. Some had difficulty accepting the idea that they needed to trust themselves in knowing what they needed to feel competent to either change the emphasis of their practice or to reenter the work force. As stated by one participant "I switched from adult rehab to a school setting. I then switched from school to hospital setting. TPP helped me to gain experience that helped me qualify for my current position." It was set up that the ILP would drive the direction the therapist would pursue. Some individuals audited courses at the University, others participated in fieldwork experiences, still others attended the workshops and/or the seminar series.

Evaluation Results

As described above, the evaluation plan yielded considerable data about the perceptions of individuals related to the effectiveness and impact of the project. Key findings related to the workshops, video series, and overall project are provided below.

Workshops

Data were collected from all participants at the beginning and end of each of the workshops. In addition, several evaluation questions were inserted to provide formative feedback related to the training. Copies of each of these forms are provided in Appendix F. The following summary highlights key findings and provides examples of the richness of the open-ended data which has not been quantified.

Data were collected on therapists' perceptions of their skills in areas of early childhood, their perceptions' of the impact of the training, their satisfaction, and needs for additional training and supports. A brief summary of the key findings are provided below.

Fifty-three participants completed Form A which was used to collect baseline data on participants. There were 41 occupational therapists, 9 physical therapists, and 3 participants from other disciplines. Twenty-nine were working full time, 11 were working part time, 7 were unemployed, and 4 were working in positions unrelated to their discipline. The majority (n=36) were direct service professionals. Facilities in which the participants were employed varied with public school systems (n=18) and hospitals (n=14) forming the largest groupings. In general, the participants were a highly experienced group with 21 reporting over 10 years of experience in pediatrics.

Of the 49 people who completed Form B, 22 were somewhat satisfied with the ways that they and their colleagues developed relationships and worked with families; 6 were highly satisfied, 5 were somewhat dissatisfied, and 5 were highly dissatisfied. The group was almost equally divided over whether or not they currently assessed family strengths and needs (23=yes, 17=no). The following are examples of the open-ended responses to the question related to how they involved family members in therapeutic services: "preliminary interview and prior to assessment to determine family strengths, needs, agendas etc., involvement in assessment, sharing info, shared goal writing, seeking appropriate help levels..."/ "no family involvement, involve teachers by reports, observations, and meeting with them,"/ "questionnaire, IEP, telephone conference, mid-year conference, annual reviews"/ "goal setting to meet family concerns/values, instruction in home activities to support therapy," / "interview , observation of their skills, modeling adaptation of skills, answers to questions, display of self knowledge of child skills, child's strengths, own strengths,"/ and "provide description and demonstration-observe and critique family/caregivers performance as able."

This group was also asked to describe any experiences that they had had with families that they found to be difficult. Responses included: "In the past when I saw very young children: particularly difficult situations in suspected abuse, the very young parents, poor attendance cases, parents in denial, poor carry-over situations,"/ "not showing up when they say they will- parent you suspect abuses child or does not "treat" the child as "I" feel is appropriate i.e., yelling, verbal put-downs'"/ "1) difficulties transitioning from clinic P.T. to school setting parents of course want to continue with as much P.T. as possible, but may not be feasible' 2) parents who think equipment/braces will "fix" their kids, 3) parents thinking their kids are "lazy" or "bad" because they aren't as active as they should be for their ages, and 4) obvious lack of follow through with home programs/ attendance at treatment sessions,"/ "a parent thinks that her child needs much more occupational therapy when we feel that he is not benefiting from the services- a parent that is not satisfied with our school services and seeks many other evaluations and opinions," and "parents who find only sorrow and no joy in their children."

Participants identified many strengths in their current service delivery systems including: "as an educator of parents and under-twos I have consistent influence and access to family. I provide information once a month in a discussion format on topics of child development and parenting issues. Availability of observation of parent-child interaction providing information on needs of children, parents, and family,"/ "identifying primary problems, interacting with other disciplines,"/ "attempts to meet the needs of the family as well as the child- very personalized and high quality services - a staff that have similar goals and who are willing to give extra effort,"/ "1) interdisciplinary approach, 2) close relations with patients' doctors, 3) importance of family involvement,"/ "multidisciplinary, good knowledge base, and creative thinking,"/ "family oriented, skill level, interaction with kids,"

Things that participants reported they would like to change about their programs included the following: "improving family interaction,"/ "I would like to focus more on goals that are set- it's easy to get away from them,"/ "1) Involve family more, 2) involve staff nurses more, 3) involve off shifts more, 4) increase follow up after discharge i.e. they receive services but to check with them if they have problems,"/ "1) good and effective collaboration with staff in programs for elementary students with severe, multiple handicaps, 2) designing and implementing therapeutic positioning programs with above staff/students, 3) adapting to needs of so many different programs," / "more involvement with other professionals involved with child, more creative service delivery, and more groups,"/ "time for team building and participation on teams besides IEP times, less travel time within school day, and documentation system that meets my needs as well as communicates appropriately to families and teachers also," / and/ " have a better understanding of families and teachers and gear my intervention more appropriately - improve my ability to communicate, negotiate, and if need be confront others more assertively - work better with children and families with different cultural backgrounds and also intensive medical needs and other intense needs - abuse neglect."

On a five point scale (1=little, 2=some, 3=adequate, 4=good, and 5=excellent), participants generated mean ratings of 4.17 on communication skills, 3.48 on interviewing skills, 3.39 on implementation skills, 3.22 on negotiating skills, 3.22 on facilitating transitions, and 2.52 on case management skills. Their satisfaction with the effectiveness of their teams, communication on their teams, and interagency collaboration were slightly below somewhat satisfied and slightly above somewhat dissatisfied. Participants described some of the strengths of their teams as: "good communication skills, compatibility, mutual support, good overall family assessment, good overall assessment, excellent knowledge base, strong family orientation, and genuine concern of all participants for the patients." Areas that need to be improved include: need to have budgeted time where we can communicate and function as a team, we are all individual pay and I often don't see the PT for months at a time, increased communication outside of meetings, to develop and expand flexibility in roles within team to quicken referral process, to expand membership - add PT, to empower team to enable adequate transitions, and more flexibility is needed and greater validation that we are all professionals."

Table 7 provides a summary of participants' satisfaction with their ability to set goals.

Table 7
Satisfaction with Workshop Content

	Excellent 4	Good 3	Fair 2	Poor 1
1) Policy Initiatives - Panel	10	15	4	
2) Providers - Panel	6	12	11	1
3) Children with HIV and Cocaine Exposure	21	8	4	
4) Specialized Care for Children (M. Brady)	7	16	3	1
5) Transitions - Parent Panel	25	4	1	
6) Educational Settings (M. Lawlor)	14	11		
7) Children with Pulmonary Needs (M. Massery)	24			
8) Overall Rating	16	8		
9) Between 4 and 3	2			

Table 8 summarizes participant satisfaction with the final workshop session.

Table 8
Satisfaction Abilities to Establish Treatment Goals

	Highly Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Highly Dissatisfied
Cognitive	5	21	10	3
Communication	2	19	16	2
Self-Care (ADL)	14	22	2	1
Play	15	15	5	3
Gross Motor	20	17	2	1
Fine Motor	16	19	2	1
Sensory Processing	13	16	7	3
Behavioral/Emotional	9	14	13	3

Evaluation Form E was used to collect therapists' perceptions of how the workshop series was affecting their practice. We received lengthy, thoughtful responses. Several examples are provided below:

"In the last six weeks, I've been spending more time observing children (about 1-2 years of age) in their homes. Due to information I received from the last workshop, I interviewed family members and caregivers regarding their own strengths/weaknesses, those that they perceive in their child, the goals that parents want for their child, stressors in everyday lives, etc. I really tried to incorporate the parents' viewpoints/opinions about their child in the interview and subsequently during the observation process."

"We have really made a more concerted effort to involve parents more across all environments (home care, school settings). Looking for more collaborative opportunities."

"I definitely consider the parents'/family needs much more. I regularly ask the family what their goals are and try to see that they are addressed."

"Workshop has reassured me that many of the skills in my present position (not in peds) will carry over into other areas of OT."

"I feel I've made more of an effort to ask families their goals for therapy, long or short term. I feel I've tried to be more open and flexible with families and options."

"I have continued to investigate employment possibilities in the Kenosha area. I have been much more aware of what and why of treatment as I visit centers. And I am much more aware of the meaning of all the alphabet soup associated with early childhood. I appreciate all the information I have collected and have for future reference in the event of employment."

"My experience with the previous workshops has influenced (broadened) my thinking in terms of the parental issues for therapists and the therapists' perceptions of the role of the family in the intervention process and course."

"As an OT working with both children and adults, I have found these workshops have considerably influenced my practice in a positive way. First, it has supported my beliefs and actions about the role of family in treatment and therefore reinforced actions about the role of family in treatment and therefore reinforced actions which I have questioned to be "professional" that I perform. It has also helped me change some not so positive actions to be more family oriented and patient oriented in the adult population as well as the pediatric population. The results are astounding as patient participation has improved, outpatient attendance increased and feedback from the patient/family more positive."

"These workshops have influenced me in many ways. They are a culminating forum to help me think about a lot of new ideas- as a parent of 2 small children, as I return to work- I've begun thinking much more of the family as the central focus and the determiner of services- the consumer; that we don't "fix" kids - that we work over time in a collaborative process to help families see their children maybe a little differently and to help adapt the environment to meet their needs. I think differently about the whole evaluation."

"I've looked at communication between professionals in a new way with a new perspective(guess I'm more conscious of people's techniques etc. used in negotiations and communicating."

Our follow-up survey is currently being conducted. As of the writing off this report, 23 out of 83 participants surveyed have returned their questionnaires. We have recently conducted follow up telephone calls to promote an increased response. We will complete a thorough quantitative and qualitative analysis of the final data set and compare baseline ratings of skills with final ratings of skills for the twenty-six areas measured. In addition, we will be able to report on the impact of the project in terms of recruitment and retention of qualified personnel in early childhood.

Our preliminary analysis of some of the qualitative comments demonstrate an impact. The following quotes are taken from participants who reported that TPP influenced their decision to change jobs: "I switched from adult rehab to a school setting. I then switched from school to a hospital setting. TPP helped me to gain experience that helped me qualify for my current position;"/ "Only confirmed that I prefer working with children;"/ "Major change in program goals- assisting in parent involvement with school and equipment choices;"/ "I used TPP to "retool" from school system practice to acute care in June, 1991; a position at my clinical site was not available so I went to Loyola. When one became available two years later, I returned to my [TPP] clinical site;"/ "I received a great deal of support, encouragement, and training to change my expertise from psychiatry to pediatrics,"/ "I'm now working in the school system as a result of TPP;" / and "Because of the training I received through TPP I feel confident in re-entering the workforce after a ten year absence."

Video Series

All of the participants who attended the Dissemination Workshop were included in a telephone interview study conducted approximately three months after the workshop. Twenty-two respondents were reached and all agreed to participate in the interview. Responses are organized around the primary questions.

1) What, if anything, came out of the Therapeutic Partnership (TPP) Dissemination Meeting that you found helpful?

001/ Design of the project useful; manual useful; tapes were well done

002/ Video tapes well received in my facility with professionals into programming; articles good; meeting well worthwhile
003/ Discussion on tapes interesting about issue
004/ Trying guide for other people to present materials; liked tapes- set up discussion
005/ Helped increase awareness of role importance of family members; thought clinical process more family-centered for 0-3 programs
006/ Heard from different perspectives how others felt about family intervention
007/ Used tapes for Illinois Association of School Psychologists; excellent training for increasing sensitivity for family needs
008/ Academic position-different from what was advertized; how family focus was identified
009/ Teaches developmental disabilities course at Chicago State-family centered approach; IEP meeting being handled and having critiques
010/ Expectations of family during evaluations; awareness of cultural differences
011/ Products; reporting on Interviewing
012/ That this existed; brush-up on skills; tape showed how IEP's can work with families; parent perspectives
013/ Liked type of staffing; increased sense of parent attitudes; parents as equal team members
014/ Hand-outs for parent support group; good information; good reinforcement; good work with students
015/ Came late
016/ Dividing people (therapists) into ranges; used in inservices; used questionnaire on rating your skills; make goals; making a plan for staff evaluation
017/ Not an educator- a Part H coordinator; but liked the increased understanding of individual needs and tailoring of needs for adults and families.
018/ Good portrayal of family
019/ Nothing specific - interesting on state levels- what Illinois was doing-mentorships a good idea
020/ Blank
021/ I don't know
022/ Liked viewpoint of psychological issues with family

2) Have you utilized the video series?

9 Yes   11 No   2 Not Yet

If yes, How?: With students- well received would use them again with students; in classroom with junior occupational therapy students - also with independent study student to define family-centered practice; used with physical therapists in Kentucky; lent to graduate student for workshop; with Principal and Speech Department; classroom-entry level physical therapy education; in class on critical thinking and communication- developmental disabilities course-seen before and after fieldwork experience; "Telling the world about them" - District 101 parents referenced them - Inservice with PEIP (Proviso Early Intervention Plan) Workshop; group setting with community agencies more geared to families - in education setting don't necessarily look at families; and with students-increase students understanding - able to use parent perspective.

If no, Do you have plans to in the future?: Not in a position to use these materials; no, need a facilitator; yes - as soon as inservice; no - not what expected tapes to be; would like to, but don't know how to use; in class - use #3 - group at early intervention team - working on transitions - inservices; staff development day in April; no - due to time; yes - staff development; change in employment - will use for staff inservice; yes - class in pediatrics to introduce family concepts like work in staffing-school information good; will be used at curriculum meeting; interested in more information on tapes; are available - too busy right now - OT/PT alliance could be used as topic - use with OT students; not clear on uses - where appropriate - copy might be appropriate to set up seminars; inservice training - to busy now; yes - will use for inservices for nursing staff; no - but have told colleges about them.

3) What, if any, additional supports or resources would be helpful?

001/ Nothing I can think of - reference list on government agencies.
002/ Facilitators manuals.
003/ Facilitators guide.
004/ Facilitators guide.
005/ Bring speaker to conferences - OT/PT working in schools - (250 members)
006/ Blank
007/ Traditional family setting - not realistic; single family issues.
008/ Not.
009/ Series on testing in ICU's; feeling of parents - Interviewing - more information on observation - more info on diversity.
010/ Inner city cultural diversity more than one culture represented; increase minority - increase lower socio-economic state representation.
011/ Speakers - to further expand on topic - additional reading materials - bibliography.
012/ Will this be done again? Inservices - goal writing - with family centered issues addressed.
013/ no, nothing I can think of.
014/ Facilitators guide. ASAP. Seminar series - need more.
015/ File - information for graduate students good resources.
016/ Facilitators guide.
017/ Better questions in guide.
018/ Blank.
019/ Develop a discussion guide - what was good/not as good - facilitators guide.
020/ Evaluation - Chandler movement assessments for infants - assessment revised Bayley.
021/ Nothing, I am not teaching anything in that area and have nothing to do with TPP.
022/ Will get other films through center - for fall class.

4) Is there anything else you would like to tell us?

001/ I was interested in the development of a training tape - Not using the tapes for instruction; more interested in the design of the program - the program itself.
002/ Look at tapes then again at six months; see if you have changed. (Develop a self-evaluation strategy)
003/ Nothing I can think of now.
004/ Beth Cada did good job of accepting criticisms - some emotional reactions - good facilitation. Spring conference on peds. - would like to try it - more info on how to do it.

005/ Nothing right now.
006/ Interns - were helpful - well take more.
007/ Not enough money for (best practice tape); increases consciousness of professionals on IEP meetings - next step. No IFSP. Birth through 4 with same staff. Trust issues with staff and follow-through between professionals - team work continuous quality same story. Next tape less sexist - more dad's involved - he is willing to help with next meeting.
008/ Well organized; what was expected?; How you implement family vs. discussing what; how therapy was delivered then to you.
009/ Enjoyed it - would like to have participated more; Good to network - and have opportunity to integrate information; good sharing - ideas; being careful about superimposing your values on others.
010/ Questionnaire - for minority parents; She would be willing to work with minority parents in gathering information on how they view therapy interventions etc. - She feels a structured questionnaire would be useful - and controllable.
011/ Happy about project, info. useful.
012/ No.
013/ Didn't need to last as long, maybe half day; too many breaks; highlights of video tapes, not entire tape; what was program about (TPP) need to be clarified.
014/ Good to be included; would like more training programs.
015/ Nothing; Missing emphasis on cultural diversity in all areas; tape require discussion.
016/ Ethnic neighborhood; other family dynamic - issues of trust; New issues visits at night.
017/ Disappointed - tapes not as applicable as she had hoped they'd be; tapes not representative of all families, particularly minorities; tapes were not clear on what "family-centered care" was, wasn't clear; not enough on the individual's independence within the family; not a real family; doesn't think May meeting of interest; Glad there was still work being done on the project; said she gave most of her feedback at the meeting.
018/ More cultural differences; panel discussions with parents - maybe fathers; questionnaire - things brought up by parents for family (minorities).
019/ Not the "best practice" tape; need something specific for developing IEP's.
020/ Video needs interactions not as an independent study; not used in the way it was designed, and I got more out of what I am doing (working on PhD) - changing into peds; has influenced my practice and my teaching in a very positive way.
021/ No, nothing.
022/ Materials well put together; is three times per week within the family process - stigma with bike ride (family issues) Goals functional? - what was the message given to families about amount of therapy needed - families guilt issues - family discussion about issues; she would like to hear what they have to say about the films.

Conclusions

1. Project activities described in the original grant proposal were successfully implemented and all goals and objectives were either met or exceeded. However, there were several shifts in emphasis based on participant need, evaluation data, and evolution of the model. Participant rates in extended practicums were less than anticipated and involvement in ongoing seminars exceeded expectations. The self study series, which was designed for individual use, was reconstructed as a group activity based on consistent and strong feedback that the issues needed to be discussed in interdisciplinary formats.

2. The use of an Individualized Learning Plan (ILP) resulted in the development of additional learning options and revealed that many practicing clinicians have learning needs that cross over the Foundational Level, Enrichment Level, and Advanced Specialization Level proposed in the original grant. The process of engaging practitioners in a collaborative process of designing programs simulated the Individualized Family Service Plan (IFSP) process. Not surprisingly, project faculty needed to establish credibility with participants about the wide range of options available in the program and facilitate the participants' active involvement in evaluating their strengths and needs and negotiating a feasible training option.

3. The movement toward the adoption of family-centered models of therapeutic services is highly complex. Unlike other approaches or technologies that have been adopted in a cumulative approach through the acquisition of new knowledge or techniques, embracing principles of family-centered care requires foundational shifts in therapists' frames of reference. This shift may require abandonment of some guiding principles. Additionally, other disciplines, parents, and program administrators need additional training in family-centered therapeutic models. We have found that organizational cultures and team expectations for therapists impeded the adoption of more innovative models of service delivery. We have found that organizational cultures and team expectations for therapists impeded the adoption of innovative models of service delivery that differed from traditional "expert" models.

4. The input of family members throughout all phases of the project substantially enhanced activities. As the project evolved, we expanded methods to incorporate the family perspective. Somewhat surprisingly, many therapists indicated that they did not have routine access to families to gather their perspectives in a reflective way. We also recognized that many parents were more comfortable with a model of participation that enabled them to selectively be involved with specific activities rather than commit to an ongoing role with limited definition of their potential contributions.

5. The model was organized around the development of partnerships with a broad range of individuals and agencies. Although the initial development of these partnerships was time intensive, we believe that these partnerships were pivotal to the success of the program and are the foundation for our ongoing activities at the termination of the funding period.

IX. Project Impact

Dissemination Activities

As stated in the grant the project provided a seminar to train representatives of state agencies and academic curricula in the surrounding states in the replication of the model. This meeting was held on November 18, 1993 at the University of Illinois at Chicago in the Illini Union. Over (200) invitations were sent out to local agencies and the neighboring states. The seminar was held for the entire day. 40 people attended from a wide range of disciplines and policy areas. See Table 3. Representatives from Illinois, Indiana, Wisconsin and Michigan attended. The agenda for the day included Dr. Lawlor giving an overview of the TPP project including TPP abstract, design, competency statements, competent therapist, ILP, health forms, AOTA fieldwork evaluation form, TPP workshop series evaluation forms. Patti Ideran discussed participant advising, Beth Cada and Fran Abramson shared the Parent Advisory Committee Report and how families were involved in the project, then there was a panel consisting of Annette Smith, project faculty, Joanne Bristol, a clinical mentor, Mary Black, and Denise McMahon, project participants, sharing their experiences. The afternoon consisted of viewing the self-study video-tape series and pursuing discussion. The entire project was well received by the participants. Many questions were raised on how this type of model would work in academia. There was also a discussion regarding the self study series and suggestions and concerns on how best to use it. Every participants requested a copy of the facilitator guide when it became available. All felt that the video-tape series would be a useful tool for both pre and post service trainees.

All attendees received an extensive manual and copies of the video tapes. Three people who were unable to attend and who requested materials received them.

Promotion of TPP activities

Over the three year period, project faculty have shared information regarding the project with many different organizations both within the state as well as nationally. The project director shared information with Dr. Audrey Witzman, Part H Coordinator, and the State Single Point of Contact. Dr. Lawlor continues to serve on the Personnel Committee of the State Interagency Coordinating Council for Early Intervention. Project faculty presented at both APTA and AOTA annual national conferences in June 1991 and again at AOTA in 1992 and 1993. The project faculty also discussed the project at the November meeting of the Early Intervention Consortium in Chicago. Press releases for state and national occupational and physical therapy publications were published. Two "Open House" meeting were conducted in Year 1 at UIC and representatives of all academic programs in the region and area clinical programs were invited.

Ms. Cada presented an overview of the project to the American Occupational Therapy Association (AOTA) Executive Board in Denver, CO, 1992, and she also presented the project at the American Occupational Therapy Certification Board Meeting (AOTCB). Ms. Cada presented Parental Expectations of Therapists at the Chicagoland Pediatric Special Interest Group in March 1993. Dr. Lawlor presented "Perspectives of Family Members on Their Experiences with Intervention" at the Illinois Association for Infant Mental Health, Wilmette, IL in October 1993; "The Role of the Therapists in Implementing the Early Intervention

Systems" at Southern Illinois University, School of Medicine, Springfield, IL in April 1993; and "Daily Dilemmas in Family-Centered Practice" at the Illinois University Affiliated Program Research Colloquia Series, in Chicago, IL in Feb, 1993. In Sept 1993, Ms. Cada and Ms. Metzger attended a workshop in Indiana, and promoted the dissemination meeting which held in November 1993.

The workshop series and the monthly seminars were advertised throughout the university as well as individual invitations were mailed to local clinical therapist.

X. Future Activities

Since the close of the funding period in December, 1993 we have conducted or have scheduled the following activities:

1. Conducted a meeting on Tuesday, February 8, 1994 to assist therapists in determining eligibility for Illinois Early Intervention Certification.

2. Ms. Cada and Dr. Lawlor conducted a three hour session with the early intervention team at the Chicago Lighthouse for the Blind on February 14,1994. They used the video-tape series and piloted the facilitator guide.

3. Dr. Lawlor has scheduled a four part evening seminar series that began March 24, 1994. The topics to be discussed include family centered care, cross cultural communication, therapeutic relationships and interdisciplinary collaboration.

4. An interdisciplinary seminar has been scheduled for May 10, 1994 and sponsored by the Maternal and Child Health Training Project (MCJ #9101), Department of Occupational Therapy entitled "Family-Centered Care: Parent and Practitioner Perspectives". Dr. Lawlor and Ms. Cada will present several of the components from the TPP model.

5. Dr. Lawlor has been invited to give a presentation about the family centered care model on May 19, 1994 to two early intervention providers in the southern suburbs of Chicago.

6. Ms. Cada and Dr. Lawlor have been invited to present the TPP model at the Fourth Annual Illinois Faculty Development Institute in Early Intervention (0-3), August 4 - 6, 1994. This institute is being sponsored by the Partnership Training for Early Intervention Services (P*TEIS) and funded by OSERS.

7. Dr. Lawlor is collaborating with the Erikson Institute to conduct a summer course entitled "Sensory Processing Contributions to Early Childhood Development" in August, 1994.

8. We will offer the course entitled "Family-Oriented Interventions" at UIC in the fall of 1994.

In addition, we will continue to collect evaluation data, prepare a grant application for Outreach, provide advising to therapists who seek additional training opportunities, and respond to requests for technical assistance from community programs through the Maternal and Child Health Project (MCJ #9101). Through related research activities, we will continue to develop a conceptual frame of reference for therapists in family-centered care.

XI. Assurance Statement

Three copies of the full final report sent to:

Ms. Mary Vest X
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U.S. Department of Education
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Washington, D.C. 20202-2626

One copy of the final report sent to:

ERIC/OSEP Special Project X
ERIC Clearinghouse on Handicapped and Gifted Children
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091

One copy of the title page and abstract/executive summary sent to each of the following addresses:

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04/01/94
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APPENDIX A

COMPETENCY STATEMENTS

Overall, the competency statements for the TPP reflect the content domains of family-centered intervention, maximizing developmental outcome, interdisciplinary collaboration, and innovative models of service delivery. It is recognized that these areas overlap but that specific competencies for each area are appropriate.

In general, a competent therapist is a person that is flexible, can utilize different therapeutic strategies, and can choose and modify interventions to fit the situational demands. A competent therapist should recognize the consequences of therapeutic decisions and effectively negotiate with family and other team members. Competencies within each of the domains should reflect these types of qualities.

DEFINITIONS OF COMPETENCY

Family-centered means that family strengths, structure, environment, needs, and goals are considered in the intervention strategy. These types of variables include family expectations, cultural background, personal interactional style, and socioeconomic factors.

Maximizing developmental outcome implies that the therapist can recognize different aspects of developmental functioning and can select appropriate strategies that will influence that developmental domain.

Interdisciplinary collaboration implies that the therapist has a clear idea of the roles and capabilities of all members on the intervention team. A collaborative therapist integrates information from other disciplines and formulates an appropriate team intervention.

Content within the innovative model domain involves recognition of the need for and the identification of different models of service delivery for early childhood intervention.

FAMILY-CENTERED COMPETENCIES

The therapist will be able to:

1. Articulate the role of the family and environment in early childhood intervention.
    - 1.1 Demonstrate an understanding of family theory.
    - 1.2 Demonstrate understanding of the role of all family members in an intervention plan.

2. Identify family strengths and needs and can incorporate this information into the treatment plan.
    - 2.1 Identify family strengths and concerns.
    - 2.2 Recognize different aspects of family functioning.
    - 2.3 Recognize the importance of parent-child interactions in early childhood intervention.

3. Effectively form relationship with family and involve them with the intervention.
    - 3.1 Communicate effectively with family.
    - 3.2 Appropriately negotiate child and family goals.
    - 3.3 Appropriately disseminate information to the all family members.

4. Demonstrate ability to develop innovative strategies that support and involve the family in the intervention.
    4.1 Demonstrate ability to develop communication strategies that are supportive of family members.
    4.2 Develop strategies which directly address a family issue.
        4.2.1 Adequately facilitate a parent support group.
        4.2.2 Adequately facilitate a toddler group.
        4.2.3 Facilitate a parent-infant group.

DEVELOPMENTAL OUTCOME COMPETENCIES

The therapist will be able to:

1. Recognize different domains of development and their relationship to therapeutic intervention strategies.
    1.1 Demonstrate a clear understanding of cognitive, social/emotional aspects of development.
    1.2 Articulate the relationship between intervention strategies and areas of development.

2. Select appropriate treatment intervention based upon evaluation results.
    2.1 Identify different types of treatment approaches.
    2.2 Articulate rationale for treatment choice.

3. Demonstrate adequate therapeutic skill with:
    3.1 children at risk for developmental delay.
    3.2 children with sensory impairments.
    3.3 children with orthopedic handicaps.
    3.4 children with medical disabilities.
    3.5 children with behavioral disorders.
    3.6 children with speech/language disorders.
    3.7 children with cognitive disabilities.
    3.8 children of substance abusing parents.
    3.9 infants who are premature.

4. Choose appropriate mode of therapeutic input (e.g., direct or consult).
    4.1 Communicate treatment ideas effectively with other members of team.
    4.2 Demonstrate the ability to help modify other members program activities and goals to OT/PT concepts.

5. Show ability to modify ongoing program based upon the situational demands.
    5.1 Demonstrate the ability to re-assess and integrate new information into a intervention program.
    5.2 Include different domains of developmental outcome in re-assessment strategy.

INTERDISCIPLINARY COMPETENCIES

The therapist will be able to:

1. Articulate the primary roles of all partners on the early childhood team.
    - 1.1 Demonstrate ability to adequately describe therapeutic objectives of the various disciplines on an early childhood team.
    - 1.2 Demonstrate a clear understanding of evaluation findings of other early childhood disciplines.

2. Design and implement an interdisciplinary early childhood intervention.
    - 2.1 Choose and administer appropriate evaluation tool.
    - 2.2 Accurately interpret child behavior in natural settings.
    - 2.3 Appropriately integrate evaluation information from other team members.
    - 2.4 Articulate appropriate goals for the intervention based upon the interdisciplinary findings.

3. Assume the role of case manager and coordinate therapeutic activities effectively.
    - 3.1 Demonstrate good communicative skills with other team members.
    - 3.2 Disseminate information to parents and other team members.

4. Provide ongoing assessment of the intervention and coordinate changes in strategy with other members of the intervention team.
    - 4.1 Formulate strategies for collecting ongoing assessment information from the other team members.
    - 4.2 Make appropriate changes in the therapeutic plan.
    - 4.3 Disseminate this information to other members of the team.

5. Demonstrate leadership in the development of treatment plan (communicates and resolves crisis among team).
    - 5.1 Demonstrate the ability to resolve differences among team members.

6. Articulate the legal and ethical dimensions of early childhood practice and act accordingly.

INNOVATIVE MODELS

The therapist will be able to:

1. Recognize different models of service delivery.
    - 1.1 Articulate different strategies of early childhood service.
    - 1.2 Identify and discuss the pros and cons of different program models

2. Show ability to formulate alternative plans of service that match the needs of the family.
    - 2.1 Recognize other aspects of service such as cost effectiveness and can adapt treatment plans to meet these needs (coordinates with other team members).

3. Critically analyze the current model of service and implements alternative models of early childhood service.

APPENDIX B

THE COMPETENT THERAPIST

The competent therapist:

1. Can define what therapy is (values intervention beyond "traditional" therapy).
2. Encourages families to ask (values parental input).
3. Helps families access other areas of the health care system.
4. Is flexible.
5. Has effective working knowledge of systems, (both service delivery and family dynamics).
6. Is able to negotiate and communicate (gets along).
7. Recognizes and celebrates successes.
8. Can make decisions.
9. Understands situational goals.
10. Has repertoire of styles (risk taker/self disclosure) and can adapt and change based upon the situation.
11. Understands the consequences of actions, can react to stimuli and uses history of experience.
12. Understands how vision of development and therapeutic frame of reference influences intervention approach.
13. Conceptualizes early childhood intervention as family and team oriented.
14. Can use treatment session as evaluation (recognizes when needs are met).
15. Recognizes the power and decision making influences of the therapeutic relationship.
16. Recognizes the "dangerous therapist."
17. Takes care of oneself.

APPENDIX C

Faculty Advising

All TPP faculty will participate in the advising of therapists. The project director or coordinator will assign advisors to therapists. The advising includes the following:

1) reviewing the application;
2) meeting with the therapist to discuss goals and programming possibilities;
3) translating the therapist's objectives into a curriculum plan;
4) follow-up meetings as necessary;
5) update and final evaluations.

Applications or individual learning program should be reviewed in order to determine the level of the therapist. This information will help determine the general nature of his/her training program. At least one meeting should be scheduled in order to match the needs of the therapist with the appropriate experiences in the program. The worksheet included with the learning plan should be used to facilitate the translation of objectives to plans and evaluation. Follow-up meetings should be scheduled only if necessary. If the program is ongoing for a long period of time, follow-up meetings should include update evaluations.

As the TPP curriculum includes lectures, clinical practicums, workshops and follow-up seminars, individualized programs can include any combination of these experiences.

APPENDIX D

PARENT ADVISORY COMMITTEE (PAC) REPORT

The TPP Project was designed to provide opportunities for occupational and physical therapists to develop skills and knowledge so that they could provide more effective services to children and their families. An important aspect in designing the curriculum to be "family friendly" was to determine what parents value from interactions with a therapist. Accessing parents who had experiences with occupational and physical therapists was more challenging than anticipated. Names of parents who have a child with a disability who have received or are receiving occupational and/or physical therapy services were solicited from therapists who worked in pediatric settings. Each potential parent participant was sent an abstract describing the TPP Project. This was followed up with a phone call to discuss the project. Parents expressed a willingness to participate in a number of different ways: being interviewed; reviewing the curriculum materials; as a trainer; and being video taped.

There were eleven parents who expressed an interest and willingness to be interviewed about their experiences with therapists. The parents had children with a variety of diagnoses who ranged in age from 18 months to 16 years of age. Due to some difficulty with scheduling, nine parents were actually scheduled for interviews. Three parents were interviewed in each session. Each interview session lasted an average of 1 1/2 to 2 hours. The parents were asked two open ended questions: "Tell me about a good experience you had with a therapist", and "Tell me about an experience you had with a therapist and how you wished it would have turned out differently." The parents were also encouraged to give other comments about their experiences with therapists. The comments were noted by the facilitator and transcribed (see attached). The comments were reviewed for themes. Four main themes were apparent. The first theme has been titled "Parents' Expectations of Therapists". This theme has three sub themes which are knowledge of skills, personal attributes and communication. The second theme is "Parents Needs/Issues", which is a broad category that includes some general issues parents face as a parent and some more specific issues related to being the parent of a child with a disability. The third theme is titled "Things That Make A Parent Angry". These comments were quite specific to the insensitivity people showed toward parents, families and children with disabilities. The fourth theme is titled "Advice and Suggestions from Parents"; the comments were a collection of statements that might help a therapist relate to a family, parent, or child.

PARENTS' EXPECTATIONS OF THERAPISTS

The most frequently heard comments were regarding therapists' ability to problem solve. Parents felt that a therapist should be able to know what is "wrong" with their child. Several parents felt that it might not be reasonable to find a therapist that is "knowledgeable" about all conditions and problems but it was necessary for a therapists to know about how to access other resources and be able to network. Several parents discussed the need for therapists to be knowledgeable about technology as it related to increasing their children's ability to function independently. Documentation was mentioned as something that is valued, using noted, evaluation results and suggestions for home. In some cases the documentation was essential for reimbursement for therapy services by third party payers. There was some discussion of the use of terminology both in written and in verbal communications. Parents reported that jargon is not helpful and at times wording can have negative meanings in different settings. The word "functional" has a positive meaning in a therapy situation but an educator may use the word in an extremely different context to suggest a low level of performance for a student. Several parents felt that a therapist should be willing to be innovative or "try something", particularly if more traditional methods have not been successful.

Parents listed affective qualities they expected from the therapists that provided service to their families. The list included being pragmatic, having the ability to listen, being on time for appointments, being flexible, and being professional. The term "professional" was defined to mean not being rude and being on time for appointments by three of the parents.

PARENTS NEEDS/ISSUES

The comments from the parents tended to group into two subthemes: parents accessing and utilizing therapy services for their children, and what parents need for themselves. Parents agreed that therapy services were hard to get, that there needed to be more therapists available to families, and because of the therapist shortage, perhaps should be trained in order to ease the therapist shortage.

Parents stated that therapy schedules need to be flexible for the parent's convenience. Parents reported that changing therapists is extremely stressful for both the parents and children. Parents asked that therapists be considerate of the demands on the family and not make family life more complicated.

Several parents discussed the issue of the availability of reimbursement for therapy services, particularly as they viewed therapy as long term service. There were reoccurring comments regarding the guilt and anxiety parents feel as a result of having a child with a disability. One parent discussed the idea that parents have dignity and would be willing to accept compassion from a therapist. All parents mentioned their need for support. The bottom line for most parents was that they wanted a therapist to meet their child's needs. Several parents also stated that they know their child best and don't feel as if therapists truly use the information they provide.

THINGS THAT MAKE A PARENT ANGRY

This thematic grouping was filled with emotion. Parents had very strong feeling toward therapists who have said "Don't worry about your child", –the implication being that the child is not very involved and is not a service priority. Another related issue is when a child was "dropped" from therapy because the therapist's case load was high. Some parents felt that therapists pick and choose children, not necessarily based on need. Parents reported that they don't like to have their child classified as a diagnostic category, .eg, "She's Down Syndrome". Two parents reported their frustrations: each time their children have changed placements, the new therapists feel as if they must completely evaluate the children and plan a new program. These parents question the reason for the total change, the inability for therapists to carry over an existing plan, and question what impact this has on their children. Parents feel that shifting information from one situation to another was extremely time consuming. One parent reported her frustration with having to intervene with the therapists on the behalf of her son's classroom teacher. According to the parent, the teacher was unable to get the assistance from the therapist she needed to assist the child in the classroom. Several parents discussed the problems of being "philosophically" at odds with the therapist. This primarily addressed the parent's feeling that the therapist was not addressing the important needs of the child, rather than the therapist not providing knowledge and skills necessary for intervention.

ADVICE/SUGGESTIONS FROM PARENTS

Parents were very willing to provide suggestions and advice to therapists; parents wanted therapists to acknowledge that children need change as they age. Therapy activities need to be fun, interesting and age appropriate. Children need to be "pushed" and given opportunities in a therapy session. Therapists should be able to help a child with his or her frustrations during a therapy session.

Therapists should be attentive to the treatment environment as it would make a major difference in outcome. Therapists should be able to engage children in therapy sessions. Parents felt that therapists should be able to identify all positive assets their children possess and make appropriate supportive remarks. One parent stated that she felt her hairdresser had a more positive relationship with her child than the therapist. Therapists should make the assumption that parents are intelligent, want to be a part of the therapy session, want regular two-way communication and are not impressed by jargon. Parents want to hear something positive about their child. Two parents specifically requested that therapists don't use the word "never" when describing their children's potential for independence. Several parents suggested that the therapist remember to include the siblings when possible. Most parents reported that they will go to a therapist another family has recommended. All parents interviewed said that "you and your child have to like the therapist."

In conclusion, the parent interviews have provided a wealth of knowledge and insight into what parents and children need and want from therapists. For the most part, parents were extremely positive about the value of therapy. I was struck with the minimal emphasis parents placed on specific theoretical approaches and techniques that therapists themselves seem to value. Generally, parents placed greater value on the relationships they had with a therapist, communication and the resources a therapist could be to the family.

RECOMMENDATIONS

1. Conduct several more interviews with parents from a variety of ethno-cultural backgrounds not represented in the initial interviews.

2. Invite several parents to review competencies for the TPP Project.

3. Investigate possibility of having families provide clinical training opportunities for TPP participants.

4. Select a family who would be willing to assist in producing a video tape of a day in the life of...for training purposes.

5. Consider asking several of the parents who participated in the interviews to become faculty for the workshop series.

6. Write an article with findings from the initial interview with the parents. The article could include the process used to recruit the parents.

Parent Meeting 4/11/91

Schedule needs to be flexible to meet parents' needs

Arrange child's therapy schedule with consideration to full-time schedule.

Parents have guilt/anxiety

Request child have integrative therapy in primary grades

Therapy needs to change as child ages-early SI, more global therapy later as child needs specific skills

Therapists need to know more about technology

Parent resents having to intervene for son and teacher

Therapist shortage the therapist drop some children

Parents don't like to be told "don't worry about your child"

"She's Down Syndrome" - rather than a diagnosis a child

Living in dread of the OT leaving

Training parents to easy therapist shortage

SI therapy? Play therapy?

Frustrated parent-parent wants child's needs met. If the child needs to learn to write his name, put a pencil in the hand verses a peg in a board

Philosophically at odds with therapist

Parent expects therapist to problem solve on an ongoing basis

Therapy activities need to be age appropriate

Every time child changes placement, the child needs to start all over again with therapist, there isn't any carryover

Frustration -services are not available

Therapists should be encouraged to help child with frustration

Parents need specific instructions

There needs to be expectations for child even though diagnosis in known (rather than for the diagnosis)

Child needs to be pushed or provided opportunities

Terminology- functional in the educational system means cleaning toilets

Parent beginning to find an alliance with a therapist

Think of other activities when a child doesn't follow usual patterns

Need to be pragmatic

Personal attributes: needs to listen, try it, do it and report back to the parents

Documentation for parents is helpful, particularly a summary

Home programs are important if based on suggestions, casual

Parent reports frustration with the lack of communication from school therapist

Suggestion- plan scheduled phone calls

Parent perception: therapist may feel that they are imposing on the family

Difficult transition from parent in charge to school in charge

Shifting information time consuming

Parent Meeting 4/10/91

Parents are told their child does not need OT because they have good fine motor skills

Need therapy goals that carry over to home

Parent feels that the school therapists pick and choose kids because the numbers are too great

How would you like a therapist to be?

Find positive things to say about their child

Be professional- not being rude

Be on time

Be reliable

Assume the parents are intelligent

Have two way conversations

Make parents feel welcome

Explain what happens

Give suggestions

Adapt to different behaviors

Individualize approach to children

Be flexible

Keep lines of communication between you and parents open

Therapy is a scarce resource in school districts

Some therapists seem reluctant to get involved

OT/PT don't feel welcome at school- perceived attitude

Parent had experience of not being able to understand their concerns, therapists always interpret the needs as fine-motor

Parent felt the therapy was skills oriented

OT is hard to get- schools don't want to hire them

Parent wanted experienced therapist who had a lot of contact with children

Want collaboration with schools

Schools do not listen to parents

How do parents know where to get specialty information?

Therapist not being familiar with a child's problem/diagnosis

Therapist need to put themselves out for a family- phone calls, having parents talk to other parents

Families need to feel comfortable with therapist approachability, have resources and support parents concerns

Therapists should know about a family, the best way to do it is get to know them over a period of time- you also have to know when to stop asking about family information

Include siblings

What do parents want to know about a therapist...

Go to the therapist that other families have recommended

You have to like the therapist

Kids need to like therapist and therapy

Therapy is part of the solution

Involve therapist

Helps if OT and pediatrician know each other

Therapist needs to know what is wrong with child

Parents need specific information on diagnosis

Parents need to know the possibilities

Never use the word "never"

Periodic documentation- is the child making gains at the expected rate?

Know child's history

Parents need support for themselves "do the best you can for Michele"

Parents need a good support system early

Parents need to see improvement

Therapists should point out the positive

Talk with other parents

Parents concerns change over time- neurologist, to school, to insurance focuses

Talk to parents in terms they can understand

Look beyond the diagnosis- don't talk about a child as a diagnosis

A good therapist asks for information and parent opinion

Try and put yourself in a parents position

Parent Meeting 3/11/91

Each therapist changes the therapy plan in the first session

Changing therapist is very stressful- 15 in one year

Parent had to seek therapy services when the school couldn't find a therapist

Parents know their children- therapists don't

Parent can pick up on verbal and nonverbal messages a therapist gives- particularly when a parent tells a therapist something the therapist doesn't believe a child can do

Therapist feels parents over-estimate their child's abilities

Therapist puts child in a category with all other children

Therapist didn't tell me what to expect

Therapist does not value parent's ideas for goals for child

Therapist needs to be flexible

Environment for treatment is important- the more natural the environment, the better for the child

Therapists should work at the child's peak time of day if at all possible

Therapist should help educate parents and advocate for them

Be knowledgeable/ be able to network other services

Parents don't know what to expect from a visually impaired child

"I haven't had a therapist over 30 years of age."

"I would like to meet a therapist who knows something different than I do."

Therapists should be:

Enthusiastic

Not be afraid to touch or look at a child

Ready to make adjustments

Don't make a family's life more complicated

You could tell parents

Are you comfortable with the situation?

I like your daughter

Sometimes I (parent) feel disgusted and empty

I have dignity and want some compassion

I would like to just blend in with the rest of the group (other families)

Parents are not getting their needs met - they are constrained by payment available for services

OT/PT's are not paid enough, are locked into system (school), they deserve to be well paid

APPENDIX E

INDIVIDUAL LEARNING PLAN
THE UIC THERAPEUTIC PARTNERSHIP PROJECT
THE UNIVERSITY OF ILLINOIS AT CHICAGO
COLLEGE OF ASSOCIATED HEALTH PROFESSIONS

1. Name: ______________________________ Date: ______________

2. Address: ____

______________________ Zip: ______ County: ______________

Phone No. (Home): ____________________ (Work): ________________

3. Discipline: OT ____ PT ____

4. What academic degrees have you earned?

		Field	Year Graduated
a.	BA/BS	____________________	__________
b.	MA/MS	____________________	__________
c.	Doctorate	____________________	__________
d.	Other	____________________	__________

5. Which of the following best describes your current position? **(Please check only one)**

___ a. Direct Service Professional

___ b. Program Director

___ c. Team Leader, Clinical Coordinator, other Supervisory Personnel

6. How long have you been working at your current position?

___ a. less than 1 year

___ b. 1 - 3 years

___ c. 3 - 5 years

___ d. more than 5 years

7. How many years in total have you worked with children? __________

8. Please check the age range(s) with which you have had at least 3 months of experience:
(Please check all that apply)

___ a. Under age 3 ___ b. Ages 3 - 5 ___ c. Ages 6 - 9

9. We would like to know how confident you feel about your skills. Your candor is helpful. Please circle the category which best describes your level of skill in the following areas:

	limited skills	some skills	adequate skills	good skills	excellent skills
a. Working with children at risk for developmental delay	1	2	3	4	5
b. Working with children with sensory impairments	1	2	3	4	5
c. Working with children with orthopedic handicaps	1	2	3	4	5
d. Working with children with medical disabilities	1	2	3	4	5
e. Working with children with behavior disorders	1	2	3	4	5
f. Working with children with speech/language disorders	1	2	3	4	5
g. Working with children with cognitive disabilities	1	2	3	4	5
h. Interviewing parents or primary caregivers	1	2	3	4	5
i. Working with parents with special needs (e.g. congnitive limitation, substance abuse, etc.)	1	2	3	4	5
j. Administering standardized assessment tools	1	2	3	4	5
k. Assessing the premature	1	2	3	4	5
l. Assessing family strengths and needs	1	2	3	4	5
m. Assessing parent-child interactions	1	2	3	4	5
n. Assessing the home environment	1	2	3	4	5
o. Observing and interpreting child behavior in natural situations	1	2	3	4	5
p. Negotiating child and family goals	1	2	3	4	5
q. Facilitating a parent support group	1	2	3	4	5
r. Facilitating a toddler group	1	2	3	4	5
s. Facilitating a parent-infant group	1	2	3	4	5
t. Providing case management services	1	2	3	4	5
u. Counseling parents	1	2	3	4	5
v. Developing integrated service plans with other team members	1	2	3	4	5
w. Resolving conflicts (parents, staff etc.)	1	2	3	4	5
x. Feeding the disabled child	1	2	3	4	5
y. Administering neurodevelopmental therapy	1	2	3	4	5
z. Managing splints	1	2	3	4	5

10. Learning Objectives: Please list what you wish to accomplish through your participation in the TPP. **(Please attach resumè)**

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

f. ______________________________

THE FOLLOWING PORTION OF THE APPLICATION SHOULD BE FILLED OUT IN CONJUNCTION WITH YOUR FACULTY ADVISOR. NOTE THAT FOLLOW-UP SEMINAR AND CLINICAL PRACTICUM ARE DESIGNATED FOR ALL LEVELS OF STUDY. SELF STUDY CASE ANALYSIS IS DESIGNATED FOR ENRICHMENT AND ADVANCED LEVEL THERAPISTS.

11. METHOD OF STUDY: **(Please circle level of study and types of instruction)**

Foundation

Lecture series
Clinical Practicum
Follow-up Seminar
Lab Practicum
Graduate Seminar

Enrichment

Workshops:
  1 Interdisciplinary collaboration
  2 Family Focused
  3 Maximizing Developmental outcome
  4 Model of service delivery
Practicum
Graduate Seminar

Advanced

Independent study
Self-study
Graduate Seminar
Advanced Practicum

12.

OUTCOME #	Review Date	Date Achieved
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

13. Revisions Based on Progress.

Date of Revision	Specific Actions	Date of Review
____________	______________________________	____________
____________	______________________________	____________
____________	______________________________	____________

Therapist Signature: ____

Faculty Signature: ____

Advisor Signature: ____

Date of Approval: ____

APPENDIX F

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form A

ID No.________

1. Discipline: OT_______ PT_________ Other (Please specify)____________________

2. What academic degrees have you earned?

"X" all that apply		Field	Year Graduated
a.	AA/AS	____________	________
b.	BA/BS	____________	________
c.	MA/MS	____________	________
d.	Doctorate	____________	________
e.	Other	____________	________

3. Which of the following BEST describes your current employment status:

a. ______ I work full-time as a therapist.
b. ______ I work part-time as a therapist.
c. ______ I am unemployed. (Please skip to number 7)
d. ______ I work in a position unrelated to my discipline.

4. Which of the following BEST describes the facility in which you work?

a. ______ Public school.
b. ______ Hospital.
c. ______ Community-based program.
d. ______ University.
e ______ Private practice.
f ______ Rehabilitation facility.
g. ______ Intermediate or chronic care facility.
h. ______ Other (Please specify)____________________

5. Which of the following best describes your current position?

"X" one

a. Direct Service Professional . . . . [ ]

b. Program Director . . . . [ ]

c. Team leader, Clinical Coordinator, other Supervisory Personnel . . . . [ ]

d. Other (Please specify) ______________________________

6. How long have you been working at your current position?

a. less than 1 year . . . . [ ]

b. 1-3 years . . . . [ ]

c. 3-5 years . . . . [ ]

d. more than 5 years . . . . [ ]

7. How many years in total have you worked with children? . . . . [ ]

8. Please check the age range(s) with which you have had at least 3 months of experience:

Birth - 1	[ ]
Under age 3	[ ]
Ages 3-5	[ ]
Ages 6-9	[ ]

9. We would like to know how confident you feel about your skills in the following areas. Your candor is helpful. Please use the following scale: I feel I have.....

1	2	3	4	5
limited skills	some skills	adequate skills	good skills	excellent skills

	I feel I have......skills					
a.	Working with children at risk for developmental delay	1	2	3	4	5
b.	Working with children with sensory impairments	1	2	3	4	5
c.	Working with children with orthopedic handicaps	1	2	3	4	5
d.	Working with children with medical disabilities	1	2	3	4	5
e.	Working with children with behavior disorders	1	2	3	4	5
f.	Working with children with speech/language disorders	1	2	3	4	5
g.	Working with children with cognitive disabilities	1	2	3	4	5
h.	Interviewing parents or primary caregivers	1	2	3	4	5
i.	Working with parents with special needs (e.g. congnitive limitation, substance abuse, etc.)	1	2	3	4	5
j.	Administering standardized assessment tools	1	2	3	4	5
k.	Assessing the premature	1	2	3	4	5
l.	Assessing family strengths and needs	1	2	3	4	5
m.	Assessing parent-child interactions	1	2	3	4	5
n.	Assessing the home environment	1	2	3	4	5
o.	Observing and interpreting child behavior in natural situations	1	2	3	4	5
p.	Negotiating child and family goals	1	2	3	4	5
q.	Facilitating a parent support group	1	2	3	4	5
r.	Facilitating a toddler group	1	2	3	4	5
s.	Facilitating a parent-infant group	1	2	3	4	5
t.	Providing case management services	1	2	3	4	5
u.	Counseling parents	1	2	3	4	5
v.	Developing integrated service plans other team members	1	2	3	4	5
w.	Resolving conflicts (parents, staff etc.)	1	2	3	4	5
x.	Feeding the disabled child	1	2	3	4	5
y.	Administering neurodevelopmental therapy	1	2	3	4	5
z.	Managing splints	1	2	3	4	5

10. Learning Objectives: Please list what you wish to accomplish through your participation in the workshop.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

f. ______________________________

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form B

I.D. NO.__________

The following questions are designed to help you reflect on your current program and how you deliver services to young children and their families. We will use the information to develop learning experiences that will address your clinical issues.

1. Please briefly describe the children (e.g., ages, types of functional problems, diagnoses) that you serve.

2. Where do you provide services (e.g., type of facility, home-based)?

3. How do you involve family members and other care providers in your therapeutic services?

4. Do you currently assess the strengths and needs of families?

_______Yes _______No

If yes, please explain how you do this.

5. How satisfied are you with the ways that you and your colleagues develop relationships and work with families?

____ Highly satisfied
____ Somewhat satisfied
____ Somewhat dissatisfied
____ Highly dissatisfied

6. Have you had any experiences with families that you found to be particularly difficult?

______ Yes ______ No

If yes, please give examples of situations that you have found to be difficult.

7. How satisfied are you with the ways in which you and your team members delineate roles and coordinate service?

____ Highly satisfied
____ Somewhat satisfied
____ Somewhat dissatisfied
____ Highly dissatisfied

8. Do you or do other members of your team systematically evaluate the effectiveness of your services?

______ Yes ______ No

If yes, please explain how you do this:

9. What do you feel are 3 strengths of your current services?

10. What are the THREE things that you would like to change about the way that you provide services?

THANK YOU

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form C

ID No. ________

Case 1.

An 18 month old child is referred to you for home stimulation because he has not begun to walk and developmental delay is of concern. On your first two visits you are welcomed by a single mother whose clean and tidy apartment is nonetheless suggestive of poverty. She co-operates fully with your interview and assessment of the child, and agrees to all your recommendations. On the way upstairs for your third visit, you hear a man yelling; he passes you on his way out of the apartment. For the first time, the 6 year old is home from school, and while he does not seem to be sick, he has a "black eye." While the mother is no less receptive to you, she offers no explanation of the man or the black eye, and she seems distracted.

(1) You are likely to feel: (please circle all that apply)

(a) concern for the mother's welfare
(b) concern for the 6 year old's safety
(c) sad
(d) helpless
(e) distracted
(f) surprised
(g) not surprised
(h) "over my head"
(i) mobilized into action

(2) You are likely to think: (circle all that apply)

a. the mother should initiate a conversation with you about the man, or the black eye

b. you should initiate a conversation about the man, the yelling, the six year old

c. you wish someone else would be assigned to this case.

(3) If the mother tells you that the man is her boyfriend, who had been drinking last night and hit the 6 year old, is really a good provider and a good father when he doesn't drink . . . . Your obligations under the Child Abuse Reporting Act are (circle the best answers)

a. call your supervisor

b. tell your supervisor on returning to the office

c. call the police from the child's home

d. call the IDCFS hotline and report suspected child abuse

(4) What other responses would you be likely to have? (Please circle all that apply)

a. drop the infant stimulation program for the day and invite the mother to talk about her personal concerns

b. offer to provide information regarding services (for substance abuse, for spouses of substance abusers, for violence between partners, for mental health assessment and treatment)

c. leave as soon as possible and call before making future visits to avoid confronting a potentially dangerous man

d. undertake to be the mother's primary confidante so she doesn't need to get involved with too many agencies

e. tell the pediatrician of the risk you observed

f. engage a social work consultant in interdisciplinary case staffing

g. tell mother you are only there for the infant and urge her to seek help

h. defer calling DCFS until you feel you have enough information that they will be likely to intervene constructively, instead of either over-reacting or under-reacting, as they so often do

Case 2.

On your second visit to a family, a neighbor offers the information that the mother and child left the night before, and tells you she can't understand why the mother didn't leave before, because her husband beats her up all the time. You ask the neighbor if the child ever "gets it too", and she says she doesn't think so.

Describe how you would feel and what actions you would take. Is there anyone in your setting with whom you would discuss these matters? At what stage? What additional information or othe input or support would you like or need to assist you in providing services to children in these situations (Please feel free to use back of page).

What would you feel and do?

THANK YOU

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form D

I.D. NO.__________

Describe how you would feel in each of the following cases and what actions you would take. Is there anyone in your setting with whom you would discuss these matters? At what stage? What additional information or other input or support would you like or need to assist you in providing services to children in these situations?

Case 1.

Whenever you visit a developmentally delayed three year old, he is in the crib. His mother never smiles at him, and while she doesn't ask you to leave, she watches the soap operas while you work with the child, evidencing no interest in learning how to carry out a stimulation program in your absence.

What would you feel and do?

Case 2.

Every word a mother speaks to her two year old girl sounds loud and angry or negative to you.

What would you feel and do?

THANK YOU

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form E

1) We are interested in learning about whether your experience at our last workshop has influenced you in any way. Please reflect on your practice over the past six weeks and provide us with comments about any changes in your thinking or practice that you have noticed.

2. We are also interested in hearing about any additional services or supports we can provide to assist you and your colleagues. Please comment on anything that you feel would be helpful to you.

Thanks again for your assistance!

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form F

1. How successful are you with your assessment process?

   Highly Satisfied   Somewhat Satisfied   Somewhat Dissatisfied   Highly Dissatisfied

2. Is there anything about your assessment process that you would like to change?

   Yes   No

   If yes, Please explain:____

   ____

   ____

3. What is your primary frame of reference in pediatrics?

   ____

4. How satisfied are you with your ability to establish treatment goals and predict outcomes in the following areas?

   1 = Highly Satisfied 2 = Somewhat Satisfied 3 = Somewhat Dissatisfied 4 = Highly Dissatisfied

Cognitive	1	2	3	4
Communication	1	2	3	4
Self-Care (ADL)	1	2	3	4
Play	1	2	3	4
Gross Motor	1	2	3	4
Fine Motor	1	2	3	4
Sensory Processing	1	2	3	4
Behavioral/Emotional	1	2	3	4

5. What kinds of information about development would be most helpful to you?

   ____

   ____

   ____

   ____

Thanks Again.

BEST COPY AVAILABLE

ID no. ______

EVALUATION FORM G
UIC THERAPEUTIC PARTNERSHIP PROJECT

1. What disciplines are represented on your team?

____

____

____

2. Would you describe your team as: ______ multidisciplinary?
______ interdisciplinary?
______ transdisciplinary?

3. Does your team have an identified team leader?

______ yes ______ no

4. What are the strengths of your team?

____

____

____

____

5. What areas need to be improved?

____

____

____

____

—over—

6. How would you describe the role of the parent on your team?

____

____

____

____

7. How satisfied are you with the effectiveness of your team?

highly dissatisfied	somewhat dissatisfied	somewhat satisfied	highly satisfied

8. How satisfied are you with the communication on your team?

highly dissatisfied	somewhat dissatisfied	somewhat satisfied	highly satisfied

9. How satisfied are you with your team's efforts at interagency collaboration?

highly dissatisfied	somewhat dissatisfied	somewhat satisfied	highly satisfied

10. Please rate your skills in the following areas:

	little	some	adequate	good	excellent
negotiating	1	2	3	4	5
implementing change	1	2	3	4	5
communication	1	2	3	4	5
case management	1	2	3	4	5
interviewing	1	2	3	4	5
facilitating transitions	1	2	3	4	5

Thank You

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form H

ID. No. ________

1. Please rate your satisfaction with each of the following sessions: (circle one)

	Excellent	Good	Fair	Poor
Policy Initiatives - Panel	4	3	2	1
Providers - Panel	4	3	2	1
Children with HIV and Cocaine Exposure (D. Gabard, M. Stabrawa)	4	3	2	1
Specialized Care for Children (M. Brady)	4	3	2	1
Transitions - Parent Panel	4	3	2	1
Educational Settings (M. Lawlor)	4	3	2	1
Children with Pulmonary Needs (M. Massery)	4	3	2	1
Overall Rating	4	3	2	1

2. Please tell us which parts of this series you have attended. (Please check all that apply)

___ Family Oriented Intervention

___ Maximizing Developmental Outcomes

___ Interdisciplinary Collaboration

___ Innovation Models of Service Delivery

3. Are currently practicing as a pediatric occupational therapist?

Yes ____ No ____

If yes, please skip to Question 5.

Turn Over Please

4. Has this series influenced your interest in accepting a pediatric position?

Yes ____ No ____

If yes, how? ____________________

5. Please tell us how your practice has changed as a result of the workshops.

6. Please list three areas in which you feel your skills have improved as a result of this series.

1. ____________________
2. ____________________
3. ____________________

7. Please list three areas in which you feel you need additional training.

1. ____________________
2. ____________________
3. ____________________

Thank You!!

UIC Therapeutic Partnership Project
Conference Evaluation
Evaluation Form I

ID No.__________

1. Discipline: OT____ PT____ Other (Please specify)________________

2. What academic degrees have you earned?

		Field	Year Graduated
a.	AA/AS	__________	__________
b.	BA/BS	__________	__________
c.	MA/MS	__________	__________
d.	Doctorate	__________	__________
e.	Other	__________	__________

3. Which of the following BEST describes your current employment status:

a. ____ I work full-time as a therapist.

b. ____ I work part-time as a therapist.

c. ____ I am unemployed. (Please skip to number 7)

d. ____ I work in a position unrelated to my discipline.

4. Which of the following BEST describes the facility in which you work:

a. ____ Public school

b. ____ Hospital

c. ____ Community-based program

d. ____ University

e. ____ Private practice

f. ____ Rehabilitation facility

g. ____ Intermediate or chronic care facility

h. ____ Other (Please specify)______________

5. Which of the following best describes your current position?

"X" one

a. Direct Service Professional . . . . [ ]

b. Program Director . . . . [ ]

c. Team leader, Clinical Coordinator, other Supervisory Personnel . . . . [ ]

d. Other (Please specify) ______________________________

6. How long have you been working at your current position?

a. less than 1 year . . . . [ ]

b. 1-3 years . . . . [ ]

c. 3-5 years . . . . [ ]

d. more than 5 years . . . . [ ]

7. How many years in total have you worked with children? . . . . [ ]

8. Please check the age range(s) with which you have had at least 3 months of experience:

Birth - 1 [ ]
Under age 3 [ ]
Ages 3-5 [ ]
Ages 6-9 [ ]

9. We would like to know how confident you feel about your skills in the following areas. Your candor is helpful. Please use the following scale: I feel I have.....

1	2	3	4	5
limited skills	some skills	adequate skills	good skills	excellent skills

I feel I have.......skills

a. Working with children at risk for developmental delay 1 2 3 4 5

b. Working with children with sensory impairments 1 2 3 4 5

c. Working with children with orthopedic handicaps 1 2 3 4 5

d. Working with children with medical disabilities 1 2 3 4 5

e. Working with children with behavior disorders 1 2 3 4 5

f. Working with children with speech/language disorders 1 2 3 4 5

g. Working with children with cognitive disabilities 1 2 3 4 5

h. Interviewing parents or primary caregivers 1 2 3 4 5

i. Working with parents with special needs
(e.g. congnitive limitation, substance abuse, etc.) 1 2 3 4 5

j. Administering standardized assessment tools 1 2 3 4 5

k. Assessing the premature 1 2 3 4 5

l. Assessing family strengths and needs 1 2 3 4 5

m. Assessing parent-child interactions 1 2 3 4 5

n. Assessing the home environment 1 2 3 4 5

o. Observing and interpreting child behavior in natural situations 1 2 3 4 5

p. Negotiating child and family goals 1 2 3 4 5

q. Facilitating a parent support group 1 2 3 4 5

r. Facilitating a toddler group 1 2 3 4 5

s. Facilitating a parent-infant group 1 2 3 4 5

t. Providing case management services 1 2 3 4 5

u. Counseling parents 1 2 3 4 5

v. Developing integrated service plans other team members 1 2 3 4 5

w. Resolving conflicts (parents, staff etc.) 1 2 3 4 5

x. Feeding the disabled child 1 2 3 4 5

y. Administering neurodevelopmental therapy 1 2 3 4 5

z. Managing splints 1 2 3 4 5

APPENDIX G

FORMING PARTNERSHIPS WITH FAMILIES

Participant's Guide

University of Illinois at Chicago
College of Associated Health Professions
Department of Occupational Therapy
Department of Physical Therapy

December 1993

Acknowledgments

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Course Introduction

This self-paced, video-based course was created through the Therapeutic Partnership Program (TPP) at the University of Illinois at Chicago, a three year federally funded interdisciplinary training project. This course was developed to provide an opportunity for occupational and physical therapists to gain an understanding of the multiple factors that influence the therapeutic process in early childhood. This course contains three videotapes. These tapes can be viewed separately, but tell a story when viewed in sequence. After viewing all three videotapes and completing the corresponding units in this User's Guide, the viewer will be able to develop an Individualized Family Service Plan (IFSP) in Unit IV.

This course is designed as an interactive learning experience. Maximum benefit is derived by viewing course materials with a partner. Partners do not have to be therapists, but could be interested team members. Selection criteria for a viewing partner should include someone who is interested and willing to reflect upon their own family experiences. It is particularly valuable to share course materials with a colleague.

All families are unique and different. Everyone has family life experiences which contribute to the way we view other families. Some situations portrayed in the video programs may create discomfort in some individuals, while others may find them very common place. Reflecting on your own family experiences will enable you to better relate to the family portrayed in this course.

Family scenarios portrayed in this course have been selected as a compilation of various family issues. The story portrayed is based upon real life experiences described by parents, which have been interpreted by therapists. Scenes were selected because parents thought they were important. No attempt was made to portray a family which is representative of all cultural issues. Instead, situations were selected which have significant impact on the daily life of a family.

Since daily life and therapeutic practice is full of ambiguities, intentional ambiguity is portrayed in the videotape programs. For example, there is never a diagnosis for the child, or a clearly stated reason for the therapy assessment. These ambiguities allow the therapist to form questions and reflect on their own practice. A deliberate decision was made to focus upon aspects of the child's life which reflect the family's strengths, needs, wants and priorities.

Exercises are designed to engage participants in the process of reflecting on the perspectives and experiences of a family engaged in the process of obtaining help for their child. There are no right or wrong answers to the exercises.

This learning experience is designed to produce a sense of discovery, a journey to develop a greater ability to appreciate individual differences among families, capitalize on their strengths, and understand how families cope with daily situations. Each participant will receive feedback from university personnel which affirms each individual's process of their journey.

Audience

This course is designed for duly certified or licensed occupational and physical therapists, or those who are enrolled in an accredited basic professional degree program. This course is also appropriate for practitioners who work with children with special needs, or who are interested in expanding their knowledge in this area.

Prerequisites

Individuals need a basic knowledge of child development, including knowledge of children with special needs. A basic understanding of family life, awareness of federal and state laws related to service provision for children and families with special needs, and an understanding of role contribution to a team are required.

Objectives

At the completion of this course, you should be able to:

- Appreciate the diversity of families by identifying characteristics in this family which make them unique.
- State the role of the family in early childhood intervention.
- Recognize, in this family, the roles and responsibilities of each of the family members.
- Describe the influence of the environment on child development and family life.
- Identify family strengths, concerns, resources and priorities, and incorporate this information into the intervention.
- Evaluate personal assumptions regarding families and reflect on how these assumptions influence your practice.
- Identify and list new strategies to engage families in identifying goals and needs important to the families.
- Effectively relate to the family by involving them in the intervention program.
- State the primary roles of all partners on the early childhood team.
- Identify strategies team members, including parents, can use to impart and exchange information effectively.
- Identify the complexities within relationships.
- Select appropriate treatment intervention based upon on-going assessment of the child's needs and the family's concerns.
- Recognize different types of service delivery.
- Develop service options that match the needs of the family.
- Design and implement a family-centered, early childhood intervention program.

Course Materials

This course is divided into four units. Units 1-3 present a videotape-based case study with topics ordered sequentially. Unit IV is designed to integrate this information.

The Participant's Guide provides overviews, objectives, activities, summaries, additional information, and exercises for each unit.

The Exercise Booklet contains the unit exercises. Exercises are located in this booklet and duplicated in the Participant's Guide for future reference.

Suggested Readings

In addition to the course materials, you will find a list of recommended readings in this packet. This list will be periodically updated.

How to Take This Course

Because this is self-paced learning, you have control over how and when you receive the course information. It is suggested that you read the information for each unit in the Participants' Guide until directed to view the appropriate videotape. After viewing each videotape, refer to the Participant's Guide to complete the activities and read the summary for each unit.

Activities within each unit are designed to provide practice that is beneficial to attainment of the unit objectives. You may complete these activities alone. However, the designers of the program believe that you achieve the greatest benefit by discussing the activities with a colleague who has viewed the videotapes.

Participant's are encouraged to complete the exercises in the Exercise Booklet and return the completed Exercise Booklet to the University of Illinois at Chicago for evaluation.

Please return the videotapes within 14 days upon receipt of the course materials. Completed exercises must be returned within 30 days of receiving the course materials. Please send returned course materials to:

The Department of Occupational Therapy
University of Illinois at Chicago
1919 W. Taylor St. (M/C 811)
Chicago, IL 60612
(312) 996-6901

Unit 1: The Family

Overview

Public policy mandates an intervention model in which the priorities, resources and needs of both the child and of his/her family are central to early childhood special education programming. Within the framework of family-oriented interventions, practitioners must take into account multiple factors that influence the therapeutic process in early childhood intervention. Activity patterns, roles and relationships of each of the involved family members become important, and parental perceptions, needs, values and expectations will considerably impact the outcomes of intervention (Bailey, 1988; Dunst, Trivette & Deal, 1988).

It therefore becomes essential that the therapist involved in early childhood intervention understands the complex dynamics that influence the decision-making process, and be able to establish effective partnerships with significant family members (Anderson & Hinojosa, 1984).

Videotape # 1, *The Family* , contains four scenes. Scene One identifies the characters, the roles they assume and their interaction styles. This scene begins to identify family strengths, needs and concerns, and illustrates how complex family life can be.

Scenes Two, Three and Four continue to present parent/child interactions, establishment of new relationships, experience with the evaluation process, reveal perceived family strengths, needs and concerns, and presents family activities and interactions during unstructured/transitional times during the day.

Objectives

Upon completion of this unit, you should be able to:

- Appreciate the diversity of families by identifying characteristics in this family which make them unique.
- State the roles and responsibilities of each of the family members.
- Describe the influence of the environment on child development and family life.
- Evaluate personal assumptions regarding families and reflect on how these assumptions influence your practice.

- Recognize, in this family, the roles and responsibilities of each of the family members.
- Recognize and identify the complexity of relationships.

Required materials

The following materials are required to complete this unit:

- Participant's Guide: Unit 1
- Videotape #1: *The Family*

Estimated Study Time

Approximately 45-60 minutes

PLEASE VIEW THE VIDEOTAPE FOR UNIT 1: *THE FAMILY.*

Activity 1.

1. Reflect upon your own family experiences as you consider the relationships and interactions of the family portrayed in the videotape. Compare the similarities and differences of this family to your own.

2. If possible, compare and contrast your perspective on this family with a colleague who has viewed this program. What things did you agree upon? What things did you disagree on? If you do not have a colleague available for discussion, how do you think your views would compare to the views held by colleagues in your work setting?

Summary

This unit presents a family scenario including a child with special needs. The videotape *The Family* presents four scenes. Scene One identified the characters, their roles and interaction styles. This scene also identified family strengths, needs and concerns, and illustrated how complex family life can be.

Scene Two continued to reveal perceived family strengths, needs, and concerns through parent/child interactions, the establishment of new relationships, and experience with the evaluation process.

Scene Three continued to reveal family strengths, needs, and concerns through family activities and interactions during unstructured times of the day.

Scene Four continued the process of unfolding the family strengths, needs, and concerns while further exploring roles, responsibilities, perceptions and interactions.

Exercise 1.

1. What have you learned about this family? List some perceived strengths and needs.
2. Describe how these perceived strengths and needs might influence planning interventions.
3. Describe the influences of the environment on this child's development and family life.
4. Recognize, in this family, the roles and responsibilities of each of the family members. State these roles.
5. Describe the complexity of this family's relationships. Identify scenes which support your response.

Unit 2: Relationships

Overview

As stated in the previous unit, families, including extended families and all support services, are central to early childhood special education programming. In videotape #1, *The Family*, it was determined that Finn would benefit from receiving occupational and physical therapy services. Videotape # 2, *Relationships*, begins after approximately six months of therapy.

The videotape *Relationships* contains three scenes. Scene One opens with Annette, the physical therapist, and Finn seated in the front lawn of the family home following a physical therapy session to help Finn learn to ride his bike. They have a dialogue regarding Finn's progress in therapy, pointing out the things he can now do better than before. This scene demonstrates a positive working relationship between child and therapist, focuses on the importance of rapport building and trust, and serves to expand viewer perception/understanding of the child.

Scene Two presents a discussion between the therapists following Annette's home visit. The therapists discuss Finn's progress in therapy and future goals. This discussion focuses on the family, particularly the parents, and their concerns regarding Finn's difficulties. They also discuss how to prepare the parents for the upcoming staffing on Finn. The purpose of this scene is to demonstrate interactions and rapport between healthcare providers. This scene provides insight into the different perspectives of each therapist, and illustrates how perspectives and assumptions are in a continual process of change as the therapists gain more insight and experience with this family.

Scene Three provides the viewer with an opportunity to gain more information about this family's life while they interact with friends and family members in leisure activities.

Objectives

Upon completion of this unit, you should be able to:

- Appreciate the diversity of families by identifying characteristics which make them unique.
- Identify family strengths, concerns, resources and priorities, and incorporate this information into the intervention.
- Recognize and identify the complexity of relationships.
- Identify strategies that impart and exchange information among team members including parents.
- Recognize different models of service delivery.

Required materials

The following materials are required to complete this unit:

- Participant's Guide: Unit 2
- Videotape #2: *Relationships*

Estimated Study Time

Approximately 30-45 minutes

PLEASE VIEW THE VIDEOTAPE FOR UNIT 2: *Relationships.*

Activity 2.

1. Discuss Finn's relationship with Annette. Does this seem like a comfortable relationship between child and therapist? State your reasons.

2. Compare and contrast your perspective on this videotape with a colleague who has viewed this program. What things did you agree upon? What things did you disagree on? How do you think your views would compare to the views held by colleagues in your work setting?

3. Discuss Finn's relationship with his family and friends. Describe the interactions between Finn, his parents, and the friends of the family.

4. Discuss the benefits and/or limitations of providing physical therapy services to Finn in the park.

5. Describe a specific example of consultation used by Liz or Annette.

Summary

Scene one of this videotape demonstrates a working relationship between child and therapist, focuses on the importance of rapport building and trust, and serves to expand viewer perception/understanding of the child. This scene illustrates the following key issues:

- Finn expresses his feelings of success in riding his bicycle and improving his balance. He also questions why he has to come to therapy, and asks the meaning of "handicapped".
- Annette is very supportive. She listens to Finn, respects his concerns, and responds to his questions.

Scene Two provides insight into the different perspectives of each therapist, and illustrates how perspectives and assumptions are in a continual process of change as the therapists gain more insight and experience with this case. Some key issues illustrated in this scene are:

- Therapists can have different perceptions and perspectives regarding a child's progress.
- Therapists can also have different perceptions and perspectives about parent's views and concerns and about events like an Individualized Education Plan (IEP) staffing.

Scene Three provides the viewer with an opportunity to gain more information about this family's life while they interact with friends and family members in leisure activities.

- Family and friend support systems are important.
- Each parent discloses feelings regarding Finn's progress with his bicycle and his participation in the summer recreation program.
- Each parent discloses feelings, concerns and questions about the evaluation reports they have received, and the upcoming transition/Individualized Education Plan (IEP) staffing.
- Sharing and support occurs between Kate and Lois.

Exercise 2.

1. List strengths, resources, concerns and priorities for the family portrayed in the videotape.

2. How would you use information from Question 1 in the intervention?

3. Describe the relationship between Annette and Finn.

4. List some strategies used by the therapists to impart and exchange information among team members including parents.

5. List some additional ways that the therapists could help the family with the upcoming staffing.

6. What are some of the different types of service delivery used in the videotape? Explain your answer.

7. Suggest ways to help the parents recognize the improvements that Finn has made.

Unit 3: The Meeting

Overview

Videotape #3, *The Meeting*, a multidisciplinary conference, takes place in the spring, after Finn has received approximately nine months of therapy services. The purpose of the meeting is to determine the appropriate placement for Finn in the following academic year. This videotape contains two scenes.

Scene One begins with a meeting with the parents and school personnel. The school personnel include: a district representative, psychologist, social worker, pre-school teacher, and Liz, the occupational therapist. Each professional presents their report regarding Finn. The reports are formal, and there is very little discussion throughout the staffing. After the reports, the district representative talks with the parents about the two options available: a developmental kindergarten, or their home school kindergarten. The parents ask a few questions regarding each placement. The purpose of this scene is to portray a staffing and to demonstrate collaboration during a time of transition.

In Scene Two, Kate and Peter share the news with Finn that he will attend the neighborhood school in the fall, and receive therapy sessions at school. The purpose of this scene is to demonstrate interactions and communications between parents and child as they discuss the outcome of the staffing.

Objectives

Upon completion of this unit, you should be able to:

- Identify and list new strategies to engage families in identifying goals and needs important to the families.
- State the primary roles of all partners on the early childhood team.
- Identify strategies that impart and exchange information among team members including parents.
- Evaluate personal assumptions regarding families and reflect on how these assumptions influence your practice.

Required materials

The following materials are required to complete this unit:

- Participant's Guide: Unit 3
- Videotape #3: *The Meeting*

Estimated Study Time

Approximately 30-45 minutes

PLEASE VIEW THE VIDEOTAPE FOR UNIT 3: *The Meeting*

Activity 3.

1. Discuss with another therapist, or therapists, your perspective on the staffing. What things did you agree upon? What things did you disagree on? How do you think your views would compare to the views held by colleagues in your work setting? How could you have improved the staffing for the parents? How could you have improved the staffing for the other participants?

2. Reflect on additional or alternative methods for presenting information to the parents at the staffing.

Summary

The videotape for this unit presents a multidisciplinary conference which takes place in the spring, after Finn has received approximately nine months of therapy services, and attended a community pre-school program. The purpose of the meeting is to determine where Finn will be attending kindergarten. This unit presents the following key issues:

- Therapists should be aware of the different ways in which the therapist, the family, and school professionals perceive the child and the family.
- Therapists need to be prepared to play a variety of roles in the staffing.
- Therapists should appreciate the central role of parents in making decisions for their children.

Exercise 3.

1. List ways in which you would have facilitated the full participation of the parent(s) in the staffing. Include strategies to engage families in identifying goals and needs important to the family.
2. What are the primary roles and contributions of all the participants in the staffing?
3. What strategies were used to impart and exchange information among team members and parents? How could communication be improved?
4. What are your impressions of the relationship between Peter and Kate? Have your impressions changed since viewing the first videotape? If so, how?
5. If you had participated in this meeting, what would you have done differently?

Unit 4: Individualized Family Service Plan (IFSP)

Overview

The purpose of this unit is to develop your skills in developing an IFSP. An IFSP is required by the federal government for any child and his/her family who are eligible for services from an early intervention program. Presently federal regulations require an IFSP for any child up to the age of three. In the near future there may be one plan required for a child throughout his/her involvement in any special program. Therefore, a conscious decision was made to ask you to prepare an IFSP for Finn and his family even though he is five years old.

" The IFSP must include:

- information about the child's status. A statement of the child's present level of physical development (including vision, hearing, and health status), cognitive development, communication development, social or emotional development, and adaptive development. These statements must be based on professionally acceptable objective criteria.
- family information, with the concurrence of the family, including a statement of their resources, priorities and concerns related to enhancing the development of the child.
- outcomes. It must include a statement of the major outcomes expected to be achieved for the child and the family, including the criteria, procedures, and timelines used to determine the degree to which progress toward achievement of the outcomes is made, and whether modifications or revisions are necessary.
- early intervention services. It must include a statement of the specific services necessary to meet the unique needs of the child and the family to achieve the outcome identified during the frequency, intensity and method of delivering services.
- dates and duration of services. It must include the projected dates for initiation and duration of services.

- a service coordinator. It must include the name of the service coordinator (from the profession most immediately relevant to the child's or family's needs) who will be responsible for the implementation and coordination of the plan with other agencies and persons.
- transitions from Part H services. It must include the steps to be taken to support the child in transition to Part B preschool services if necessary. "[1]

Objectives

Upon completion of this unit, you should be able to:

- Recognize different models of service delivery.
- Develop service options that meet the needs of the family.
- Select appropriate treatment interventions based upon on-going assessment of the child's and family's concerns.
- Design and implement a family-centered early childhood intervention program.

Required materials

The following materials are required to complete this unit:

- Completion of Unit's 1, 2 and 3
- Videotapes #1, #2, and #3
- Appendix A: MDC report

Estimated Study Time

Approximately 60 minutes

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[1] Federal Register (1993). Part III, Department of Education, Early Intervention Program for Infants and Toddlers with Disabilities; Final Rule. Washington, DC: U.S. Government Printing Office.

Activity 4.

1. List the families resources, priorities, and concerns as expressed in the videotapes.

2. List Finn's priorities and concerns as expressed in the videotapes.

3. List Finn's strengths and needs as described by the team.

4. List your recommendations for services for Finn. Include some service delivery options.

5. Compare this form to the form you are using in your center. List similarities and differences.

6. Contact your state Part H office and request copies of the regulations that apply to your situation.

Summary

To complete the requirements for this unit, you must view the videotapes and complete the exercises for Units 1-3. The information for the IFSP will be gathered from the previous units.

Unit 1, *The Family*, presents the family's strengths and concerns expressed during the day.

Unit 2, *Relationships*, continues to present the family members in different situations and relationships.

Unit 3, *The Meeting*, demonstrates and expresses more of the family's concerns and demonstrates some strengths, such as communication among family members.

Review the summaries from Units 1-3. They will help you identify some of the goals that the family and Finn might want to attain when developing an IFSP. Take care to develop realistic goals for this family. Be creative in considering and including family wishes as you perceive them.

Exercise 4.

1. Enclosed is an IFSP sample form. Please complete this form after finishing Activity 4.

Individualized Family Service Plan (IFSP)

Child's Name: ____

Birthdate: ____________________ Age: _______________________

Developmental Levels:

Fine Motor_______months Gross Motor________months

Cognitive_______months Language________months

Self-Help_______months Social/Emotional________months

Child Strengths and Needs:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:_______________________

Family Strengths and Needs:

Outcomes:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Outcome: #1

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Outcome: #2

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Outcome: #3

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Notes on the IFSP Process:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Back Cover Sheet - IFSP

Child's Name: ___________________ Birthdate: ______________

Address:____

______________________________ Phone: _________________

Service Coordinator (Case Manager):

IFSP Team Members and Signatures:

Frequency, Intensity, and Duration of Services:

IFSP Review Dates: ____________________ _____________________

____________________ _____________________

Transition Plan: ________ Not Applicable ____ Yes, (See outcomes)

Parent Signatures(s):

This plan represents our wishes. I (we) understand and agree with it, and I (we) authorize Project ________________________________ to carry out this plan with me (us).

_____________________________________ ___________________

Parent(s) Date

_____________________________________ ___________________

Parent(s) Date

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Appendix

Appendix A:

Report from the Multidisciplinary Conference:

Social Service Evaluation

Reason for referral:

Finn is a 5 1/2 year old boy who was referred for evaluation through district #150 to assist in determining appropriate classroom placement for the fall.

Medical and Developmental History:

Finn was born at 32 weeks gestation via cesarean section. His neonatal course was complicated by respiratory distress and apnea. He remained hospitalized for approximately 40 days prior to his discharge. Since then, Finn has reportedly been in good health, and has had no major medical problems. Finn's mother reports that his motor developmental milestones were delayed in comparison to his older siblings. She reports that Finn sat at 10 months of age and walked at 19 months. At three years of age he underwent preschool screening through district #150. Although he passed the screening, he demonstrated difficulty with gross and fine motor skills. Finn's parents were advised to seek occupational and physical therapy services, on a private basis, to promote his motor development.

Current Situation:

Finn is the youngest of three children living at home with both parents. Finn has an eight year old brother and a twelve year old sister. The family appears to be very organized and supportive, and were delightful to work with. Finn currently attends the Sunnydale preschool program three days a week and continues to receive private occupational and physical therapy services on a weekly basis. Finn's parents report that Finn has made progress in his preschool and therapy program, but are concerned about his placement for the fall. They appear to have a good understanding of Finn's needs and the services available to them.

Psychological Evaluation

Finn was given psychological evaluation on May 29, 1993. Finn was accompanied to the session by his mother and father. After several verbal prompts, Finn reluctantly accompanied the examiner to the testing area and had some difficulty separating from his mother. During the assessment he was very attentive, but tended to be rather impulsive. As assessed by the WISC-R, Finn demonstrates average to low average scores, with a verbal score of 105 and a performance score of 83. He appears to have his greatest difficulty with visual-motor items, including block construction and pencil-paper tasks.

Preschool Report

Finn has been attending Sunnydale preschool for the past year. He is very social, is liked by his classmates, and appears to be a real leader. Another child in the classroom is in a wheelchair and uses a touch-talker to communicate. Finn interacts well with her, is supportive, and makes her feel welcome in the group. In the classroom Finn is attentive and follows directions well. He is able to identify colors and shapes, can write his name, and is learning to cut with scissors. He still requires occasional assistance in organizing tasks, and requires additional effort to complete coloring and paper-pencil tasks. His occupational and physical therapists were able to visit our preschool program and were very helpful in providing classroom and playground activities for Finn. He can now successfully zip his own coat and manipulate the snap on his pants for toileting. On the playground, I've noticed that he is still hesitant to go on some of the equipment, but when given time and space, he will get out there and try. Finn is spirited, persistent and tries to include others.

Occupational/Physical Therapy Report

Finn has been followed privately by occupational and physical therapy for approximately one year. He has been receiving direct occupational and physical therapy on a weekly basis, with consultation services provided to his family and preschool program. Finn is a very likable and friendly child who is attentive, persistent and tries hard to do his best. He continues to have some difficulty in organizing tasks, but performs well in a structured environment. His occupational therapy program has focused on improving his fine-motor/manipulative skills, dressing skills and organizational skills. He can now manipulate most clothing fasteners but continues to have some difficulty in tying his shoes. He is now able to color within the lines, but continues to work very hard at completing fine-motor tasks. His physical therapy program has focused on improving his gross motor development and coordination. He can now pedal his bicycle independently and demonstrates better control and coordination during hopping, skipping and running tasks.

Appendix B:

Glossary

Assessment:	the on-going procedures used by appropriate qualified personnel throughout the period of the child's eligibility to identify the (a) child's unique strengths and needs, and the services appropriate to meet those needs, and (b) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.
Evaluation:	the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility consistent with the definition of "infants and toddlers with disabilities", including determining the status of the child in each of the developmental areas: (a) cognitive development, (b) physical development, including vision and hearing, (c) communication development, (d) social or emotional development, (e) adaptive development.
Frequency and Intensity:	the number of days or sessions that a service will be provided, the length of time the service is provided during each session and whether the service is provided on an individual or group basis.
IFSP:	Individualized Family Service Plan: a written plan for providing early intervention services to a child eligible and the child's family.
IEP:	the written Individualized Education Program that school systems must develop, with parents' participation, to meet the educational needs of each child identified as requiring special education and related services.
Multidisciplinary:	the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

Occupational Therapy: includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school and community settings.

Physical Therapy: includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.

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FORMING PARTNERSHIPS WITH FAMILIES

Exercise Booklet

University of Illinois at Chicago
College of Associated Health Professions
Department of Occupational Therapy
Department of Physical Therapy

December 1993

Introduction

This exercise booklet accompanies the self-paced, video-based course *Forming Partnerships with Families.* It is suggested that you read the information for each unit in the Participant's Guide until directed to view the appropriate videotape. After viewing each videotape, refer to the Participant's Guide to read the summary and complete the activities for each unit. Exercises are located in this booklet and duplicated in the Participant's Guide at the end of each unit. Participant's are encouraged to complete the activities and exercises in the Participant's Guide, which they may keep for future reference. Unit exercises, duplicated in this booklet, are to be completed and returned to the University of Illinois at Chicago for evaluation.

These exercises are designed to engage participants in the process of reflecting on the perspectives and experiences of a family engaged in the process of obtaining help for their child. There are no right or wrong answers to the exercises.

Please return this completed Exercise Booklet within 30 days of receiving the course materials. Each participant will receive feedback from university personnel which affirms each individual's process of their journey.

Please send this completed Exercise Booklet to:

The Department of Occupational Therapy
University of Illinois at Chicago
1919 W. Taylor St. (M/C 811)
Chicago, IL 60612
(312) 996-6901

UNIT 1: The Family

Exercise 1.

1. What have you learned about this family? List some perceived strengths and needs.

2. Describe how these perceived strengths and needs might influence planning interventions.

3. Describe the influences of the environment on this child's development and family life.

4. Recognize, in this family, the roles and responsibilities of each of the family members. State these roles.

5. Describe the complexity of this family's relationships. Identify scenes which support your response.

Unit 2: Relationships

Exercise 2.

1. List strengths, resources, concerns and priorities for the family portrayed in the videotape.

2. How would you use information from Question 1 in the intervention?

3. Describe the relationship between Annette and Finn.

4. List some strategies used by the therapists to impart and exchange information among team members including parents.

5. List some additional ways that the therapists could help the family with the upcoming staffing.

6. What are some of the different types of service delivery used in the videotape? Explain your answer.

7. Suggest ways to help the parents recognize the improvements that Finn has made.

Unit 3: The Meeting

Exercise 3.

1. List ways in which you would have facilitated full participation of the parent(s) in the staffing. Include strategies to engage families in identifying goals and needs important to the family.

2. What are the primary roles and contributions of all the participants in the staffing?

3. What strategies were used to impart and exchange information among team members and parents? How could communication be improved?

4. What are your impressions of the relationship between Peter and Kate? Have your impressions changed since viewing the first videotape? If so, how?

5. If you had participated in this meeting, what would you have done differently?

Unit 4: Individualized Family Service Plan (IFSP)

Exercise 4.

1. Enclosed is an IFSP sample form. Please complete this form after finishing Activity 4.

Individualized Family Service Plan (IFSP)

Child's Name: ____

Birthdate: ___________________ Age: ______________________

Developmental Levels:

Fine Motor_______months Gross Motor________months

Cognitive_______months Language________months

Self-Help_______months Social/Emotional________months

Child Strengths and Needs:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Family Strengths and Needs:

Outcomes:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:_______________________

Outcome: #1

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Outcome: #2

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

Child's Name:______________________

Outcome: #3

Strategies/Activities:

Criteria/Timelines:

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

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Back Cover Sheet - IFSP

Child's Name: ____________________ Birthdate: ______________

Address:____

______________________________ Phone: _________________

Service Coordinator (Case Manager):

IFSP Team Members and Signatures:

Frequency, Intensity, and Duration of Services:

IFSP Review Dates: ____________________ ____________________

____________________ ____________________

Transition Plan: ________ Not Applicable ____ Yes, (See outcomes)

Parent Signatures(s):

This plan represents our wishes. I (we) understand and agree with it, and I (we) authorize Project ________________________________ to carry out this plan with me (us).

______________________________________ ____________________

Parent(s) Date

______________________________________ ____________________

Parent(s) Date

Johnson, B.H., McGonigal, M.J., & Kaufmann, R.K. (Eds.) (1989). Guidelines and recommended practices for the Individualized Family Service Plan. Office of Special Education, U.S. Department of Education.

APPENDIX H

Partnerships Between Therapists, Parents, and Children

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Photo courtesy USPHS

Introduction

Occupational and physical therapists provide essential services to infants and young children and their families and bring valuable perspectives to interdisciplinary early childhood teams (Dunn, Campbell, Oetter, Hall, & Berger, 1989; Effgen, 1988). Their contributions are particularly evident in situations in which early childhood development is disrupted by disabilities or vulnerabilities in gross motor, fine motor, sensory, play, and activities of daily living domains. Expansion of early intervention and early childhood programs, development of community based programs, and movement toward family centered services are providing therapists with challenges and opportunities to improve their services for children with special needs.

Pediatric practice has evolved dramatically in the past two decades. Significant changes have occurred in the numbers and proportions of therapists providing services, the development of frames of reference, applications of technology, and models of service delivery. Occupational and physical therapists provide services in educational settings, community based programs, and homes through early intervention and home care services.

There is a severe shortage of qualified occupational and physical therapy personnel to meet the needs of young children with disabilities and their families. Recent projections suggest that the shortages will reach crisis proportions in the next five to ten years (NCCIP, 1989). Unless additional therapists are recruited into early child-

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hood programs, and the skills of current therapists enhanced or upgraded, young children and their families will not have access to necessary and beneficial therapeutic services.

Occupational and physical therapists who work with young children recognize the need to improve their abilities to respond to the needs of families. Many therapists who are currently practicing received their training at a time when the medical model of practice was emphasized and less was known about early childhood development and the influences of family life and environments on developmental outcomes. In general, practitioners report that they received limited training in methods to develop an understanding of family needs and implement family centered approaches to interventions (Hanft & Humphry, 1989).

Until recently, educational programs emphasized the role of the therapist as an expert and presented models for family involvement that conceptualized family members as potential extenders of therapy. Increasingly, occupational and physical therapists, like other early childhood disciplines, are reframing their approaches to facilitate the development of partnerships with families and other members of the service delivery team. Therapists, and representatives of other disciplines, have identified the need for interdisciplinary training initiatives that enable them to learn from other professionals and develop the interpersonal skills required for effective team functioning (McCollum & Thorpe, 1988; Edwards and Handley, 1992.)

Basic professional preparation also promoted the belief that the primary model of therapeutic intervention was direct, "hands-on," child centered services (Bazyk, 1989). Models of indirect service and consultation received limited attention. Over the past several years, leaders in both professions have advocated expanding the use of consultation and indirect services in early childhood programs. "Best practice" is viewed as individually designed packages of direct, indirect, and consultation services (Bundy, 1991). Recent studies of pediatric practice reveal that therapists report that they spend only approximately 10–15 percent of the work time in delivering both indirect and consultative services (Lawlor & Henderson, 1989; Bundy, A., Lawlor, M., Kielhofner, G., & Knecht, H. 1989, Hanft & Humphry, 1989).

At the University of Illinois at Chicago (UIC), we have been working with therapists, parents, and other professionals to develop strategies to promote family centered services and to address the needs of practitioners who wish to improve their effectiveness in early childhood practice. The purpose of this article is to describe these initiatives and share some insights that we have gained related to promoting partnerships between therapists, families, and other professionals.

Overview of the UIC Therapeutic Partnership Project

The University of Illinois at Chicago (UIC) Therapeutic Partnership Project is funded by the Office of Special Education Programs, U.S. Department of Education. The program design was based on our experiences with a Maternal and Child Health Training Project entitled "Advanced Competencies in Maternal and Child Health for Occupational Therapists." Through the graduate program, research, and continuing education activities of this project, we identified the need to provide leadership in the development of interdisciplinary models for family centered therapeutic interventions and a comprehensive in-service training program for community based occupational and physical therapists.

This three-year interdisciplinary in-service training project is designed to address the manpower shortages, promote models of therapeutic practice that are family centered, and provide a professional development program. We believe the solutions to the manpower shortages involve the following: (1) *recruiting* therapists into early childhood practice who have not been working or who are working in other practice areas; (2) *retraining* therapists who need additional training to meet the new demands in early childhood practice; and (3) *enhancing* the skills of advanced practitioners so they can provide specialized care to children with complex health care problems and their families.

The curriculum model integrates didactic and practicum experiences in four major domains: (1) family centered services, (2) maximizing developmental outcomes, (3) interdisciplinary collaboration, and (4) innovative models of service delivery.

The philosophy of the program is that "best practice" results when therapists: (1) form effective partnerships with young children, their families, and other providers; (2) recognize, respect, and integrate the perspectives of all members of the intervention team including families; (3) share the responsibility for service planning and implementation; (4) use their knowledge and apply their skills in a cost-effective manner that maximizes developmental outcomes; and (5) contribute to the effectiveness of partnerships by sharing their expertise and learning from other partners. It is our belief that genuine collaboration in determining the needs, goals, and methodologies of our interventions is most likely to result in favorable outcomes for children.

Through our studies of pediatric practice and the training needs of practitioners, we have identified a continuum of professional development needs. Therapists must engage in a process of lifelong learning to integrate new knowledge and adapt their intervention strategies to accommodate new demands and the needs of emerging populations (e.g., children with AIDS, very premature infants, and children exposed in-utero to toxic substances).

UN photo 45613 by L. Solmssen

We collaborate with practitioners in the development of Individualized Learning Plans (ILP) that identify their needs, capitalize on their strengths, and address learning objectives. The ILP process provides an opportunity to simulate the collaborative process necessary to develop effective Individualized Family Service Plans (IFSP).

Perspectives of Parents

Throughout the design and implementation phases of the project, we have collaborated with families, community clinicians, and members of related disciplines. The input that we have received from parents has been particularly valuable. Parents, who have a child with an illness or disability, have served as advisors and project faculty. During the first year of the project, we conducted focus group interviews with parents who expressed an interest and willingness to be interviewed about their experiences with therapists. Their comments were noted and reviewed for themes. Four main themes emerged, the first being **parents' expectations of therapists.** This theme had three sub-themes which were: knowledge of skills, personal attributes, and communication. The most frequently heard comments were regarding therapists' ability to problem solve. Several parents felt that it might not be reasonable to find a therapist that is knowledgeable about all conditions and problems, but it was necessary for a therapist to know how to access other resources and be able to network. The second theme was **parents' needs/issues,** which was a broad category that included some general issues parents face as parents and some more specific issues that relate to being the parent of a child with a disability. Some examples of parents' needs included: flexible therapy schedules; not having to change therapists; and that therapists be considerate of family

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time. The third theme was **things that make a parent angry**. These comments were specific to insensitivity that people showed toward parents, families, and children with disabilities. The fourth theme was **advice and suggestions from parents.** These comments were a collection of statements that might help a therapist relate to a family, parent, or child. For example, therapy activities need to be fun, interesting, and age appropriate, and parents would like to hear something positive from a therapist about their child.

For the most part, parents were extremely positive about the value of therapy. We were struck with the minimal emphasis parents placed on specific treatment approaches and techniques that therapists themselves seem to value. Parents placed a greater value on the relationships they had with a therapist, communication, and the resources a therapist could bring to a family.

Lessons We Have Learned

Movement to more family centered models of service delivery requires a reframing of many of the traditional assumptions that support therapeutic practice. Many therapists are challenged by the need to make foundational shifts in their practice including a redefinition of the nature of the work of therapy, development of collaborative partnerships, forming new types of relationships with parents and other caregivers, and implementation of service delivery systems that are more responsive to the needs of families.

Although these changes are complex, we have been particularly impressed with the willingness of people to think in different ways. There is a climate of readiness for change. The impetus for change has developed both from organizational demand and the inherent commitment of therapists to adopt strategies that will maximize the effectiveness of their services. At this point in the project, we have collected valuable data that support our belief that many therapists have changed their attitudes and are beginning to introduce changes in their practices.

However, this change in attitude reflects only the beginning phase of the change process. Many therapists have reported to us that they are struggling to achieve structural changes within their practices. We recognize that changing practice takes more time, support, and resources. For many therapists, movement towards more family centered practice places both their professional identity and self-esteem at risk. For the therapists to successfully achieve foundational shifts in their practice, they need organizational supports and a facilitative climate. Through the UIC Therapeutic Partnership Project, we are moving towards training models that are institutionally based and that integrate all team members and representatives of the families who receive services.

Changes in the nature of the relationship with families pose particular challenges for therapists. Therapists who were trained in an expert model of practice often find the transition to collaboration and shared decision making difficult. Although collaborative approaches to therapy are not new, collaboration based on expert models often involved encouraging the parents to "buy-in" to the plans of the therapist. Shared decision making throughout all phases of the intervention process is a distinctly different process. Effective collaboration occurs when therapists and parents form relationships that enable the development of a shared understanding of the needs, expectations, hopes, and contributions of all partners. Progress in moving towards more collaborative models is hampered by our lack of understanding of the characteristics of optimal relationships between therapists and families. Through narrative interviewing with families and therapists, we are in the process of identifying the essential limits.

Perhaps the most important lesson of the project has been the recognition of the value of engaging parents and therapists in discussions about family centered therapeutic practice. Therapists want more opportunities to talk with parents and parents want more opportunities to talk with therapists. Both the parents and the therapists have reported that they have achieved better understandings of the perspectives of their partners. This understanding should facilitate the process of forming effective relationships. ♦

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APPENDIX I

The following products were specifically developed for this grant. Items marked with an asterisk are available for distribution.

Guidelines and Forms:

1. An Individualized Learning Plan*:
   This plan was developed to be used by TPP participants to help identify their strengths and needs and set goals to be accomplished throughout their work with the TPP project.

2. Competency packet which includes competency statements and a description of the attributes contained in "A Competent Therapist."*

Videos:

1. Three part video tape series: ***Forming Partnerships with Families***:
   Tape 1: *The Family**
   Tape 2: *Relationships**
   Tape 3: *The Meeting**

2. A video tape that contains interviews of expert therapists regarding their beliefs about family-centered practice entitled: ***Therapists' Perspectives on Family-Centered Care****.

3. Twelve videos depicting either training sessions or treatment sessions with children with special health care needs.

Publications:

1. A Participant's Guide which accompanies the video study series

2. Lawlor, M.C. & Cada, E. (1993). Partnerships between therapists, parents, and children. Osers News in Print, V(4), 27-30.

3. Three masters theses were written using data collected as part of the UIC Therapeutic Partnership Project:

   Hart, R. (1992). A descriptive study of non-practicing occupational therapists in Illinois. Chicago: The University of Illinois at Chicago.

   Costello, P. (1994). Occupational therapists in Illinois: Practice patterns and self-ratings of early childhood competencies. Chicago: The University of Illinois at Chicago.

   Wald, D. (1994). Perceived changes in practice following training in early childhood. Chicago: The University of Illinois at Chicago.

APPENDIX J

PRELIMINARY RESULTS OF A STUDY OF OCCUPATIONAL AND PHYSICAL THERAPISTS IN ILLINOIS

Introduction

The aim of this project was to collect information regarding occupational and physical therapists working in Illinois, their patient populations, their reasons for having left the profession and their needs to re-enter the profession to practice as therapists. A total of 276 respondents returned surveys.

Description of Respondents

Respondents included 133 (48.4%) occupational therapists and 142 (51.6%) physical therapists. There were 25 (9.1%) male and 249 (90.9%) female respondents. The earliest year of registration reported was 1931. Eleven therapists registered before 1950, 25 between 1951 and 1960, 70 between 1961 and 1970, 90 between 1971 and 1980 and 102 between 1981 and 1990. Most of the group (84.2%) reported that they were currently licensed while 4.4% reported that licensure had lapsed and 10.3% were inactive. Respondents reported membership to professional organizations as 51.2% belonging to the American Occupational Therapy Association, 36.1% belonging to the Illinois Occupational Therapy Association, 40.5% belonging to the American Physical Therapy Association and 36.5% belonging to the Illinois Physical Therapy Association.

In response to inquiry about academic degrees earned, 99.2% of the sample reported a bachelors degree, 26.8% had obtained masters degrees and 1.1% had obtained doctorate degrees. In terms of certification in areas of specialty, 9.2% reported certification in the Neuro-developmental Therapy Basic course, 6.6% in the Southern California Sensory Integration Test, 4.7% in the Sensory Integration and Praxis Test, 2.9% in the Neuro-developmental Therapy Baby course and 0.4% in the Brazelton Neonatal Assessment Scale.

Description of Respondents' Patient Populations

Respondents reported the most experience with clients of the age ranges of 22 through 65 years (90.5%), 66 and older (81.4%), 9 through 21 years (71.9%), 4 through 8 years (58.0%) and less with the ages 1 through 3 years (44.9%) and birth through 12 months (35.8%).

The amount of time spent with clients in specialty areas is reported in Table 1.

Table 1. Amount of time spent with clients in specialty areas.

	never	<1 yr	1-3 y	4-6 y	7 & >
Pediatrics	31.3%	21.7%	16.5%	10.9%	19.6%
Adult Developmental Disability	61.2%	9.0%	13.8%	8.0%	8.0%
Geriatrics	21.6%	8.0%	31.0%	19.2%	20.2%
Psychiatry	60.7%	15.7%	12.0%	4.2%	7.3%
Sports Medicine	69.3%	10.1%	11.6%	5.3%	3.7%
Physical Medicine/ Rehabilitation	14.3%	13.0%	31.3%	15.7%	25.7%
Orthopedics	22.0%	9.8%	28.5%	16.8%	22.9%
Acute Neurology	34.5%	11.3%	32.0%	9.9%	11.8%
Cardiac Rehabilitation	61.4%	20.7%	13.6%	1.6%	2.7%
Work Hardening	71.1%	14.4%	12.3%	1.6%	

The respondents were a relatively experienced group with a mean of 12.2 years of experience. Experience ranged from one to 42 years. The settings that most therapists had worked in was acute care/general hospital (83.6%) followed by home health care (48.2%), out-patient clinics (43.8%), rehabilitation hospitals (41.6%), nursing homes (39.4%), private practice (36.5%), public school systems (32.5%), residential/institutional facilities (23.4%), university (19.3%), community agency programs (.0%), private schools (10.6%).

When asked which area of specialty they would most like to work in, respondents indicated pediatrics (25.4%), physical medicine/ rehabilitation (19.6%), orthopedics (15.8%), geriatrics (6.5%), teaching and research, (5.8%), psychiatry (5.0%), sports medicine (3.8%), work hardening (2.3%), acute neurology (1.9%) cardiac rehabilitation (1.5%) and adult developmental disabilities (0.8%).

Therapists evaluation of their clinical skills

Therapists were asked to evaluate their skills. Response to how confident they felt about their skills is reflected in Table 2.

Of the respondents, 71.5% therapists reported that they were currently working and appointed in the position of staff therapist (37.4%), senior therapist (19.5%), department head (10.8%), program director (4.6%),academic positions (2.1%), private practice (7.2%). clinical specialist (2.1%), contract therapist (3.1%), consultant (2.6%)and supervisor (2.1%). The longest time that therapists had been working in their current positions was between one and three years (43.1%), followed by less than one year and more than six years (both 19.5%) and lastly, between 4 and 6 years (17.9%).

Table 2. Therapists evaluation of their clinical skills.

		PERCENTAGE				
MEAN	SELF-ASSESSMENT SKILL	LIM	SOME	ADE	GOOD	EXCE
3.148	Developing integrated service plans	16.7	16.0	20.2	30.0	17.1
3.061	Assessing home environment	13.7	20.6	24.4	28.2	13.0
3.019	Resolving conflict	14.9	19.5	27.5	25.2	13.0
3.004	Interviewing parents	17.9	18.3	22.9	27.1	13.7
2.728	Work with kids with orthopedic dis.	23.0	22.3	23.0	22.3	9.4
2.701	Assessment of family strengths/needs	22.7	23.1	25.0	19.7	9.5
2.543	Work with kids with medical dis.	27.9	21.9	23.0	9.9	3.8
2.542	Observe/interpret child's behavior	27.3	26.5	19.3	18.6	8.3
2.519	Administer standardized tests	30.5	20.6	21.0	22.1	5.7
2.432	Negotiating child & family goals	33.3	21.6	20.8	17.0	7.2
2.419	Assess parent-child interaction	29.1	30.9	14.3	20.4	5.3
2.355	Manage splints	38.6	23.5	20.8	17.4	4.5
2.331	Neurodevelopmental therapy	31.2	30.0	18.3	15.6	4.9
2.263	Provide case management service	40.8	17.2	23.3	12.2	6.5
2.245	Work with kids at risk	46.8	19.2	8.3	14.0	11.7
2.214	Council parents	42.0	22.5	15.3	12.6	7.6
2.167	Work with kids with cognitive dis.	42.6	24.0	11.8	27.1	13.7
2.129	Work with parents with special needs	41.8	22.1	22.1	9.5	9.6
2.068	Work with kids with sensory dis.	47.3	21.2	14.0	12.1	5.3
2.053	Work with kids with behavioral dis.	46.8	18.6	20.9	9.9	3.8
2.011	Facilitate parent support group	52.7	16.0	14.9	10.3	6.1
1.996	Feed disabled child	47.0	25.4	12.9	10.6	4.2
1.882	Facilitate parent-infant group	59.8	15.5	10.6	10.6	3.4
1.881	Facilitate toddler group	56.3	14.2	15.3	13.4	0.8
1.815	Work with kids with language dis.	58.5	14.3	15.8	9.8	1.5
1.569	Assess premature kids	67.6	18.7	6.5	3.8	3.4

Respondents who are not currently working as therapists

Of the 41.3% respondents who reported that they were not at present working in either occupational therapy or physical therapy, 57.6% were working full time in other work and 42.4% part time in other work. The last year in which respondents worked as therapists ranged from 1953 to 1991. The mean age when respondents stopped working as therapists was 40 years with the range of ages from 23 to 70 years. Economic factors did not play a role in the decision to stop working as a therapist for 72.3% of the respondents. Of the 27.7% respondents who stopped working as a therapists as a result of economic reasons, 65.2 % reported that their salary was not needed to contribute to household finances, 50% reported that there were other economic factors related to their decision to leave the profession, 26.1% reported that their salary did not cover day or child care cost and 26.1 % thought that OT or PT were not economically competitive.

When these therapists were asked whether any aspects of their job or career influenced their decision to stop working as a therapist, the responses were that the hours were too long (8.7%), the hours were not flexible (8.7%), some had an opportunity for a change in careers (43.5%), excessive documentation (23.9%), some needed a degree in an area other than OT or PT (13.0%), some needed an advanced degree in OT/PT (2.2%), some felt that their skills were not sufficiently current to do a good job in today's work force (17.4 %), some felt that they did not receive adequate pre-service training to be a good therapist (10.9 %), some were burnt out by their case load and clientele (32.6%), some had an opportunity to go into their own business 6.5%), others reported too many negative work experiences (poor work climate, poor staff relationships, lack of supervision, etc.) (32.6%), limited opportunities for career advancement (30.4%), disillusionment with OT/PT (19.6%), unhappiness with their chosen area of specialization (2.2%), a few wanted to switch specialty areas, but did not have the background to do so (6.5%), some felt that the profession was not challenging (8.7%). In a few cases, the contract was not renewed (2.2%) and nobody reported that the position was terminated.

On being asked whether family-related issues influenced their decision to stop working as a therapist, 66.3% responded that this was the case; 69.8% left to raise a family, 11.3% could not find a position with flexible hours which was compatible with family responsibilities, 11.3% left because of personal illness or disability, 7.5% left because of care taking responsibilities for other family members and 3.8% reported that the family relocated and they had been unable to find an appropriate job in the new location.

Respondents who are considering a return to work as a therapist

When asked if they had any interest in ever resuming practice as a therapist, 32.5% reported that they were considering returning and 28.2% were not sure.

Respondents were asked what they believed they needed to resume their careers. Results are reported in Table 3.

Table 3. Therapists' needs in order to resume their careers.

Therapists' needs	Yes	No	Don't know
Review of basic theory	45.7%	43.5%	10.9%
Knowledge of current theory & clinical practice	85.4%	10.4%	4.2%
Re-take certification exam	2.2%	88.9%	8.9%
Obtain state licensure	23.4%	74.5%	2.1%
Re-entry program for specific needs	63%	26.1%	10.9%
Affordable re-entry education	64.4%	28.9%	6.7%
Continuing education course close to home	83.0%	8.5%	8.5%
Continuing education programs with hours compatible with family responsibilities	76.1%	17.4%	6.5%
Feedback to help me know whether my current skills are adequate to practice	87.5%	12.5%	
Confidence in my clinical skills	78.3%	17.4%	4.3%
Assistance in finding employment commensurate with my skill level	31.1%	46.7%	22.2%
Find employment with flexible hours compatible with family obligations	71.1%	20%	8.9%
To find employment in my area of specialization	55.6%	33.3%	11.1%
To feel that I could compete effectively with younger or more experienced therapists	56.8%	34.1%	9.1%

APPENDIX K

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Table 4
Participants in Year 3 Seminar Series

Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Parent	1		1	1		1	1	1		1											7
Physical Therapy																1					1
Speech and Language Pathology																			1		1
Occupational Therapy																			1		1
Occupational Therapy											1										1
Physical Therapy																				1	1
Occupational Therapy															1	1	1				3
Anthropologist																			1		1
Physical Therapy									1												1
Occupational Therapy					1	1	1		1												4
Occupational Therapy	1		1							1											3
Occupational Therapy																				1	1
Occupational Therapy												1	1	1				1		1	5
Child Development																	1	1			2
Physical Therapy									1												1
Occupational Therapy									1												1
not available													1	1							2
not available									1												1
Psychology																				1	1
not available									1			1	1								3
Physical Therapy											1										1
Occupational Therapy																				1	1
Physical Therapy									1	1		1	1					1		1	6
Physical Therapy																			1		1
Occupational Therapy	1	1		1	1															1	5
Physical Therapy																			1		1

Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Occupational Therapy															1						1
Occupational Therapy																				1	1
Occupational Therapy															1						1
Respiratory Therapy																				1	1
Occupational Therapy															1		1				2
Physical Therapy																	1	1			2
Registered Nurse																				1	1
Occupational Therapy	1									1					1						3
Occupational Therapy																			1		1
Occupational Therapy	1					1		1							1			1			5
Occupational Therapy			1	1	1		1	1	1	1							1				8
Occupational Therapy	1	1	1	1																	4
Occupational Therapy	1	1																			2
Physical Therapy																				1	1
Physician																				1	1
Nursing																				1	1
Physical Therapy	1																				1
Physical Therapy									1												1
Physical Therapy																			1		1
not available					1																1
Physical Therapy																				1	1
Occupational Therapy	1																				1
Occupational Therapy				1	1	1	1	1					1	1	1	1	1	1			11
Physical Therapy																				1	1
Registered Nurse																				1	1
Occupational Therapy		1	1	1	1	1	1	1			1										8
Occupational Therapy									1		1		1	1		1		1			6
Occupational Therapy														1							1

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Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Physical Therapy																			1		1
Occupational Therapy																1					1
Physical Therapy																1					1
Physical Therapy											1										1
Occupational Therapy									1		1										2
Occupational Therapy															1	1					2
Physical Therapy									1												1
Occupational Therapy	1																				1
Occupational Therapy														1						1	2
Occupational Therapy																				1	1
Occupational Therapy																			1		1
Occupational Therapy	1				1																2
Physical Therapy																			1		1
Occupational Therapy	1	1	1		1		1				1	1	1	1		1					10
not available																	1				1
Pediatrics																				1	1
Occupational Therapy																			1		1
Occupational Therapy																1	1	1			3
Respiratory Therapy																				1	1
not available																			1		1
Occupational Therapy																				1	1
not available																	1				1
Occupational Therapy	1																				1
not available																				1	1
Occupational Therapy	1																				1
Occupational Therapy																				1	1
Occupational Therapy																		1	1		2
Occupational Therapy															1			1			2

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Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Physical Therapy																			1		1
Occupational Therapy	1																				1
Occupational Therapy	1								1		1				1						4
Physical Therapy									1			1	1	1					1		5
Occupational Therapy					1																1
Occupational Therapy					1	1										1					3
Physical Therapy																			1		1
Social Work																				1	1
Occupational Therapy																			1		1
Occupational Therapy		1	1	1																	3
Occupational Therapy											1										1
not available	1																				1
Occupational Therapy		1	1						1		1		1		1		1	1			8
not available																		1			1
Speech and Language Pathology																				1	1
not available	1																				1
Occupational Therapy														1							1
Occupational Therapy	1	1	1				1			1							1	1		1	8
Occupational Therapy																				1	1
Occupational Therapy																			1		1
Anthropologist	1																				1
Occupational Therapy		1			1	1	1	1	1	1					1						8
Occupational Therapy															1	1			1	1	4
Occupational Therapy																			1		1
Occupational Therapy									1		1			1							3
Occupational Therapy	1	1	1		1	1															5
Occupational Therapy																	1	1			2
Occupational Therapy																				1	1

Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Occupational Therapy																				1	1
Occupational Therapy																			1		1
Occupational Therapy									1	1											2
Occupational Therapy															1	1	1	1			4
Occupational Therapy	1																				1
Occupational Therapy		1		1											1	1					4
Physical Therapy										1											1
Occupational Therapy	1	1	1																		3
Physical Therapy												1									1
Registered Nurse																				1	1
Occupational Therapy																			1		1
Occupational Therapy											1										1
Occupational Therapy	1								1		1										3
Physician															1		1				2
Physical Therapy	1																				1
not available																	1	1			2
Occupational Therapy																	1			1	2
Occupational Therapy																			1		1
Occupational Therapy																				1	1
Speech and Language Pathology																				1	1
Speech and Language Pathology																				1	1
Part H. Coordinaor																			1		1
Registered Nurse																				1	1
Part H. Coordinator																			1		1
Physical Therapy												1				1					2
Physical Therapy																		1			1
Physical Therapy																				1	1
Occupational Therapy											1										1

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Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Occupational Therapy	1		1							1											3
Special Education																			1		1
Parent Coordinator																			1		1
Physical Therapy																		1			1
Physical Therapy	1								1	1	1		1	1	1		1	1		1	10
Physical Therapy											1					1					2
Physical Therapy																			1	1	2
Occupational Therapy																			1		1
Occupational Therapy															1	1					2
Parent																			1		1
Physical Therapy											1									1	2
Special Education																			1		1
Occupational Therapy																				1	1
Social Work					1																1
not available															1	1					2
not available													1								1
Occupational Therapy																1					1
Occupational Therapy															1	1					2
Physician																				1	1
Physical Therapy																			1		1
Speech and Language Pathology																				1	1
Occupational Therapy	1	1	1																		3
Occupational Therapy	1																		1		2
Occupational Therapy									1		1			1							3
Physical Therapy									1												1
Physical Therapy									1			1	1								3
not available																1					1
Part H. Coordinator																			1		1

Participants by discipline	11-19	1-21	2-4	2-18	3-11	3-25	4-8	4-22	5-6	5-20	6-3	6-24	7-8	8-26	9-23	9-30	10-21	10-28	11-18*	12-3	Total
Special Education																			1		1
Physical Therapy													1	1						1	3
Total participants	29	13	13	8	13	8	8	6	23	11	18	8	13	13	20	20	17	19	35*	44	339

* Denotes TPP Dissemination meeting